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A Course of Lectures

ON

THE NATURE AND TREATMENT OF DEFORMITIES.

DELIVERED AT THE ROYAL ORTHOPÆDIC HOSPITAL, MAY 1860.

BY

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SURGEON TO THE HOSPITAL.

LECTURE III.

TALIPES VARUS CONGENITUS.

[*Concluded from page* 575.]

Treatment. The treatment of congenital talipes varus will depend upon the nature of the deformity, the age of the patient, and the position of the bones of the foot. You will remember that I stated that the deformity will be met with in every amount of severity in children and adults; and in some cases, in infants, it exists with the slightest amount of muscular contraction. I might more properly say, that it is rather a tendency to, than an actual, inverted position; the inversion being at all times slight, but more evident during the exercise of the muscles. These are cases which can be treated mechanically, inasmuch as there is but slight disturbance of the balance of power between the abductors and the adductors. Free movement is possessed by both; but the adductors possess a preponderance, and turn the foot inwards. By retaining the foot, therefore, in the everted position for some weeks, by means of the instrument I have recommended for the more severe forms of infantile talipes varus (Fig. 11), first adjusting the foot-piece to a right angle, the adductors become weakened by the constant extension and inability to contract upon themselves, whilst the adductors can so contract, and the balance of power is thus restored.

Fig. 11.

There is also another slight form of congenital varus which exists without muscular contraction, and is confined to the arch of the foot, which is increased transversely as well as longitudinally, giving a rounded appearance to the foot, which becomes more apparent as the child grows older. In these cases, a steadily continued pressure, by means of the tin splint (Fig. 12) bent at a right angle, will effectually remove the

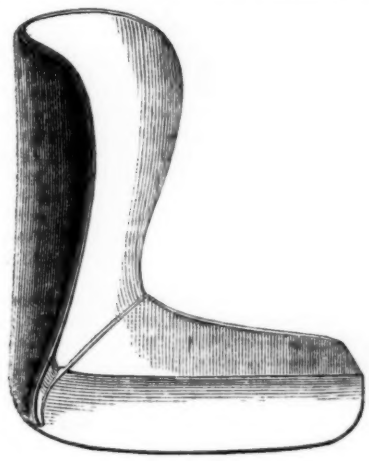

Fig. 12.

deformity. Division of the plantar fascia is advised and practised, as well as of the fascia covering the adductor pollicis; it is a perfectly unnecessary operation, and one to which I have never found it necessary to have recourse. These slight cases, then, are the only forms of talipes varus in which I consider exclusively mechanical treatment admissible.

When the deformity is more severe, the contraction of the muscles, though slight, being permanent, I find division of the tendons of the contracted muscles necessary, even in infancy. Then arises the question, at what age? If an operation is necessary—if it is desirable to operate in order to remove the deformity—then the earlier it is done, the better, in my opinion. I say in my opinion, because the advice commonly given is that mechanical treatment alone should be adopted until the child is able to walk. The deformity or malposition being thus allowed to remain during the time when the child is growing more rapidly than at any other period, the bones, ligaments, and muscles, are permitted to grow in the malposition; the muscles on the one side contracted upon themselves, on the other at their full extent of elongation. At the same time, all exercise is effectually prevented by the use of mechanical appliances, and increased development of the muscles is therefore out of the question; whilst the longer they are allowed to remain in the contracted state, the more rigid does the contraction become. By the removal of the deformity at the earliest period, the muscles, bones, and ligaments grow in their proper relative position, and are rendered capable of exercising their various functions even before the child has commenced to walk; and, as soon as the patient is capable of walking, he does so in the natural and proper manner. The numerous cases upon which I have operated, both at the Hospital and in private practice, bear unquestionable testimony to the advantages of this mode of practice; in all instances, therefore, the earlier the operation is performed the better, especially before the irritation of dentition commences.

After six or eight weeks, if the case has been carefully managed, the instruments may be removed during a portion of the day, and the patient allowed to exercise the full power of using the legs. This is a great advantage over the continued confinement occasioned by the application of splints and bandages, which the supporters of the opposite mode of treatment are in the habit of recommending; and even when this restraint has been long submitted to, the operation must invariably be had recourse to at last.

The tendons which you will find it necessary to divide are those of the tibialis posticus, the tibialis anticus, and the gastrocnemius. When this Hospital was first opened, the only tendon upon which operation was performed for infantile talipes varus was the tendo Achillis. The tibialis posticus, in youths and adults, was exposed by incision, the sheath laid open, and the tendon taken up upon a director, so that the division of the posterior tibial artery might be avoided. In the infant this was never attempted, nor any tendon divided but the tendo Achillis; and failure was the result. I therefore adopted a mode of dividing the tendon without exposing it first, with the stilette and cannula; puncturing the fascia with the stilette, withdrawing it, and then introducing the blunt pointed knife through the cannula. By this means, puncture of the artery was impossible, and the division was rendered safe. We now puncture the fascia with the common scalpel, and then use the blunt pointed knife. I have recently invented a knife (Fig. 13). This is fitted with two blades—one a scalpel, the other blunt pointed. The incision having been made with the scalpel in the ordinary manner, by the pressure of the thumb upon a small screw attached to it, the blunt pointed blade is moved down, guided by the scalpel to its place behind the tendon. The sharp edge is then turned towards the tendon, and the division is effected. Whichever mode is adopted, the greatest care and delicacy is required.

Fig. 13.

The posterior tibial tendon, you will remember, lies flat upon the tibia, its sharp edge alone presenting. The interspace, therefore, between the tendon and the tibia is scarcely more than a linear one. In the infant, this is at all times difficult to trace, and even in the adult, from the edge of the tendon being slightly raised above the tibia. I have often seen the tibia mistaken for the tendon.

The following is the best mode of proceeding. Let the patient lie on his side, with the inner side of the leg placed directly upwards. In infants, feel carefully for the edge of the tibia; for, although in a thin child the tendon may be felt upon extending and flexing the foot alternately, yet in fat children this is impossible. Having satisfied yourself that your finger or thumb is upon the edge of the tibia, you then introduce your scalpel *perpendicularly downwards*, and make a slit of a quarter of an inch in the fascia. Introduce the blunt pointed knife, also perpendicularly, and carry it to about the breadth of the tendon, between it and the bone; turn the sharp edge of the knife towards the tendon, at the same time directing the assistant to forcibly abduct the foot; when, if the tendon have been divided, a distinct sense of sudden yielding will be felt, and at times the separation may even be heard by the assistant. Never hurry the operation, nor forget the slight interspace there is between the tendon and the tibia; and remember that, if your knife is not introduced perpendicularly, you will pass over the tendon on the one side, or come into contact with the bone on the other, when you will not succeed in getting the knife behind the tendon without great difficulty—a difficulty of which I have often been a witness. Apply your lint and strapping, and then proceed to divide the tendon of the tibialis anticus, turning the patient upon his back, so that the front of the foot is upwards; the assistant grasping with one hand the leg, and with the forefinger of the other the foot. You then feel for the anterior tibial tendon, which is generally easily found, on the inner side of the front of the foot, where it passes over the ankle-joint. Introduce your knife on the outer side, pass it directly under the tendon, and divide it from below upwards. Then turn the patient with his face downwards, and feel for the tendo Achillis, which, in infants, will be found lying almost directly over the posterior tibial artery, on the inner side of the leg. Introduce a sharp pointed knife on the *outside* of the tendon, so as to avoid any risk of puncturing the posterior tibial artery; pass it horizontally beneath the tendon; turn the sharp edge of the knife towards it, and divide it from below upwards, as in talipes equinus. Then apply lint and strapping; bandage the foot carefully from the toes upwards; apply a small padded tin splint, bent to the position of the foot, so as to prevent any undue pressure. Let the leg be kept in a horizontal position; and in about four days you will find the punctures healed. You then apply your mechanical means. The best apparatus for the infant is one I have had made, and have used for many years (Fig. 11), consisting of a back and a side piece, connected by a hinge, the back-piece attached by means of a rack or cog-wheel to a foot-piece. The foot is to be bandaged carefully, and then placed in the instrument, with the foot-piece extended. You then abduct the foot, by passing the webbing strap, which is attached to the side-spring, over and just behind the front part of the foot, as in Fig. 11. After full abduction of the foot, which in these infantile cases seldom occupies more than a week or ten days, you gradually flex it by means of the cog-wheel, at the same time keeping up steady pressure on the instep by means of the lower strap, so as to reduce any increase of the arch of the foot, which is occasionally met with in these cases. When the foot is fully flexed, and the inversion overcome, the instrument may be omitted during the day, and an ordinary boot or shoe substituted, resuming the instrument at night, so as to prevent the possibility of a relapse. This will certainly take place, unless this precaution is observed; for the cicatrices occasioned by the division of the tendons, as I have before observed, do not resolve themselves into their permanent state for some few months.

A different mode of proceeding has been adopted and recommended in these young cases, namely, that of first dividing the anterior and posterior tibial tendons; then abducting the foot, as in the older patient; and afterwards dividing the tendo Achillis. This subdivision of the operation in infants is perfectly unnecessary. Another practice has also been introduced; namely, that of dividing the fascia passing over the adductor pollicis, and at times even the plantar fascia. This is also an unnecessary step; at least, I have never seen the necessity for it.

I must not omit to mention the chance there is of dividing the posterior tibial artery, even with the blunt pointed knife. When this accident happens—and it will occasionally occur, in spite of the greatest care—I would advise your postponing the division of the anterior tibial tendon and tendo Achillis for fourteen days, keeping up during that time a firm steady pressure with pledgets of lint, strapping, and bandage, to guard against any risk of false aneurism, one instance of which occurred to me many years ago, in which I was compelled to cut down and tie the artery.

In older patients, the deformity being aggravated by time and exercise, there will be found a great additional obstacle to the restoration of the foot to its normal position; the contraction of the ligaments and fascia of the sole occupying, under the most favourable circumstances, some months in the after treatment. In these cases, you will do well to divide the anterior and posterior tibial tendons and the plantar fascia first, and abduct the foot before dividing the tendo Achillis. The tendo Achillis retains the os calcis firmly in its extended position, and enables you to act upon the foot with much more certainty than can be done when that tendon has been divided with the others. The division of the two first named tendons is a much easier operation in the adult than in the infant, as the loose fat common to children has been absorbed, and the tendon is left sufficiently prominent to be felt through the integuments. If you direct the patient to adduct the foot while you place your forefinger upon the tendon of the tibialis posticus, about two inches above the internal malleolus, you will feel the tendon rise above the edge of the tibia; and a careful examination will enable you to feel the interspace between the bone and tendon. You then introduce the scalpel perpendicularly, as in the former instance; make the slit in the fascia; and then with the blunt pointed knife divide the tendon, as before described. Apply your lint, strapping, splint, and bandage; keep the foot warm and at rest for four or five days; and then commence your mechanical treatment. The best appliance is a simple straight splint, extending from a little below the trochanter major to about ten inches below the foot. This must be well padded and bandaged all the way up on the outside of the leg. At the lower end of the splint, a webbing strap should be fastened, sufficiently long to pass round the front part of the foot and buckle. By this simple means you can keep up a steady continued extension, and completely abduct the foot, without pain, which must always be guarded against in all cases.

If there is no increase of the transverse arch of the foot (which is often produced in the older patient by pressure on the fourth and fifth metatarsal bones in walking), and as soon as all tendency to inversion of the foot is overcome, you proceed with division of the tendo Achillis in the ordinary manner, and treat the case as one of talipes equinus, a full description of which was given in the last lecture.

In the old cases, division of the plantar fascia will assist the treatment, as follows:—Let the assistant grasp the lower part of the leg with one hand, and the front part of the foot to be

operated upon with the other, and endeavour forcibly to extend the foot. By this means the plantar fascia is tightened. You then introduce a sharp pointed knife on the outside of the fascia, pass it horizontally beneath it, and divide from below upwards. It should be observed that this operation, when the necessity for it exists, should be performed at the same time with the division of the anterior and posterior tibial tendons.

In cases where the increase of the transverse arch is extreme, the fourth and fifth metatarsal bones pressed inwards towards the first and second, before you proceed to divide the tendo Achillis and flex the foot, it will be necessary to unfold the arch, so to speak, and to raise the fourth and fifth metatarsal bones, which will be found partially dislocated at their tarsal extremities; or the patient, after flexion of the foot, will have his whole weight thrown upon the outer edge of the fifth metatarsal bone, and be in a worse condition than he was before the operation. To effect this object, I have used a "double-screw pad" (Fig. 14), having three pads; two small ones, applied

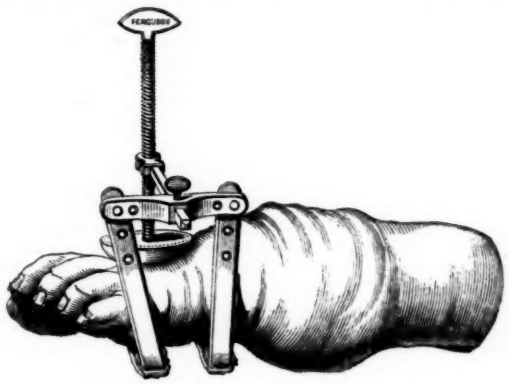

Fig. 14.

under the fourth and fifth metatarsal bones; and one larger, to be applied on the upper surface of the first and second. By means of the screw, a steady continued pressure and counter-pressure may be kept up; in applying which, however, great caution must be exercised to avoid *undue* pressure, as well as pain. With these precautions, the worst cases may be effectually treated.

When the foot has been thus unfolded, to effect which will be found by far the most difficult part of the whole treatment, you proceed, as in the former case, with division of the tendo Achillis, etc.

After the foot is fully flexed, apply a boot and iron, similar to the one represented in Lecture II, which must be worn constantly until the foot has gained strength. In infants, a tendency to rotation inwards of the whole leg is at times present; so that, when the child begins to walk, the foot, although previously in position, is directed inwards and towards the opposite extremity, so retaining the deformed appearance. This tendency ceases of itself at the end of four or five years, if not interfered with. It may, however, be prevented, in the meantime, by the application of irons attached to the boots on the outer side, and extending to the hips, with free joints throughout, and a strap at the upper extremity, passing from one iron to the other, behind the pelvis, by tightening which, the inversion of the foot may be prevented.

The removal of the os cuboides has been recommended and had recourse to, for the treatment of adult varus. It is not only perfectly unnecessary, but a direct and inexcusable mutilation.

University of St. Andrews. The next examination for the degree of Doctor of Medicine, will commence on Monday, the 24th of September. Fellows and members of the Royal Colleges of Surgeons of England, Edinburgh, and Dublin, of the Faculty of Physicians and Surgeons of Glasgow, and licentiates of the London Apothecaries' Company, are eligible for examination. Every candidate is required to communicate by letter with Dr. Day, the professor of medicine, fourteen days before the period of examination, and to present himself to the Secretary for registration, on or before Saturday, the 22nd of September.

Lettsomian Lectures

ON

THE OPHTHALMOSCOPE AND ITS APPLICATION.

DELIVERED BEFORE THE MEDICAL SOCIETY OF LONDON.

By HAYNES WALTON, Esq., F.R.C.S., Surgeon to St. Mary's, and to the Central London Ophthalmic Hospitals, etc.

Lecture II (*concluded from page* 598).

In passing to speak of the morbid changes of the *Retina* and *Choroid*, I must adhere to what I said in my first lecture as to conciseness and mere outline, and give but a very brief notice. My time will not admit of more; besides, ophthalmoscopic detail cannot be taught in this way; to attempt it would be to ensure tediousness, and not profit.

We now get a general idea of the vitality of the eye, as we judge of a person's general health and vigour by a look at his face. We now speak of anæmia, or of a reddened fundus of the eye, as we have been wont to say the countenance is pale or plethoric, and, as a rule, the indication is equally valuable for generalisation. It is a matter on which we very frequently want to be informed, and a glance will suffice our purpose.

Retina. Perhaps the commonest morbid change in the retina is *Hyperæmia*. The colour of the fundus of the eye is changed, being more red, and sometimes of a dark red. A portion of the optic disc is obscured by vessels, or the whole is covered thinly, so that the disc is yet made out, or thick enough almost to obscure it, and then its position may be more readily traced by the vessels as they pass outwards, but which soon lose their distinctness.

This is a state that always exists in a greater or lesser degree with the train of symptoms called by Dr. Mackenzie "asthenopia", and supposed by him to be a defect of adjustment only. His reasoning is clear and powerful; his conclusion is inevitable, and, but for the ophthalmoscope, every one must have been satisfied with it. It is worth referring to as an example of the fallacy that we may fall into by attempting to solve such subjects by reasoning alone. I may recall the disease to the minds of my hearers by telling them that "asthenopia" is the "choroiditis" of Tyrrell. It is the affection of those who for the most part get their living by minute sight. They are obliged to discontinue with their work, because the vision as it were gets fatigued, and the objects confused or indistinct, and vanish from view altogether. A slight cessation, a wink of the eyes, a look at a distant object, or, in the worst cases, a pause for a minute or two, enables them to continue. It is strange that the indistinctness comes on when the vision is required to be sustained on minute things only, and not when large and distant objects are looked at. But it is not peculiar to the overworked eye. I have seen it in children learning to read, in the idle man of pleasure, and in the vigorous mechanic. I begin to think that it is almost a defective of organisation, rendered worse or apparent under much or peculiar use of the eye, and the general inutility of treatment, short of cessation of that employment which renders it annoying, tends to this conviction. I could fain dwell longer on it.

Among other ophthalmic revelations of retinal changes, are those of *dots*, or *patches of white*, usually seen in the aged, and associated with feeble vision. I do not know that their nature has been made out.

Œdema of the retina, rendering the membrane pale and of a yellowish tinge, less shining than in health, and apparently raised around the optic disc, is fully recognised.

Pigment Deposit on the retina, in every form of spot, and in extent from a few dots to almost complete covering, with but small interspaces, is the most remarkable change in this tunic, and not less is the absence of any coexisting external symptoms. I have seen an amount of deposit that seems incompatible with any vision on first examination of a patient for slight feebleness of vision, which is, of course, a physiological puzzle. Many times I have doubted the visual power till I have carefully tested it.

Choroid. The choroid, like the retina, becomes *hyperæmic;*

but the most striking change is *Atrophy*, chiefly manifested by the removal of its pigment; a common consequence of chronic inflammation. The alteration generally begins near the optic disc. At first a yellowish change is seen, and then the orange-coloured choroidal vessels appear, and these become more distinct, ultimately disappear, and leave a white spot, which is often mistaken by the inexperienced for the optic disc, especially if the disc be injected. With the loss of pigment, there is a deposit of grey or deep black spots in other parts, as if the colouring matter was removed from one portion and taken to another. Associated with this, extravasated blood, in small quantities, is not very unfrequent, so that the whole fundus of the eye has a mottled and variegated appearance, and withal a person may be able to read. These alterations rarely exist without some disease of the retina.

Early in my professional career, indeed in my studentship, I suspected that in so-called *Syphilitic Iritis* there was something more than the name at first led me to infer, and this chiefly on account of the subsequent damage, the very defective eye that often remained after the iris had recovered. I was particularly attracted to this in a young woman, during my dressership. The eye seemed perfect when the inflammation was passed, yet she could hardly count my fingers. Well do I remember this being attributed by the gentleman, whose patient she was, to deficiency of active treatment in the first instance, a remark which explained nothing. The evidence of implication of the eyeball by several local and general symptoms were unheeded by me, for I looked on them, as I was taught, merely as the consequences of an inflamed iris, that being the part which the disease primarily attacked, and on which it spent its violence. It was with inexpressible delight, some years after, that I read Dr. Jacob's most valuable monograph on inflammation of the eyeball, and became convinced by it that iritis, so called, was not disease of the iris alone, but general inflammation of the eyeball; and, indeed, who ever saw the iris discoloured and paralysed by inflammation from syphilis, or rheumatism, or struma, without vision being materially impaired? I have ever found that Dr. Jacob's writings stand the test of time, and are less eclipsed by the advancement of knowledge than those of any modern ophthalmic author. Ophthalmoscopic examination does not render them obsolete, but adds confirmation.

It is no longer a secret why syphilitic eyes become spoiled. With but faint implication of the iris, and little symptom of redness and pain, the retina may be spoiled, as we see by the deposit of lymph, and choroidal damage is subjoined by structural alterations. I once gave a wrong prognosis in a case of rheumatic inflammation of the eyeball, that annoyed me for a long time, and created a great desire to discover the cause of an eyeball being so insidiously lost. With but very slight external evidence of implication of the iris, I gave assurance of complete recovery; but, to the great disappointment of all, blindness ensued. This, together with ophthalmoscopic experience, has taught me always to give a guarded opinion, and I may here remark, with regard to prognosis in general, that most of us are too apt, in critical cases, at a great risk to our reputation and comfort, and without any adequate advantage to ourselves, to be too prophetic, and to promise too much. It is true that patients almost force us into it, and when we commit ourselves, it is our desire for a favourable issue that betrays us.

A more extended knowledge of syphilitic disease of the eye, has convinced me that the posterior part of the eye, certainly the retina and the choroid, and perhaps also the vitreous humour (which is indicated by haziness and flocculi), are always involved. I never saw an example without impaired vision, and all observers know that vision may become misty prior to any palpable iritis. Before I ever looked through an ophthalmoscope, I made the vision the chief ground of diagnosis in the incipient stage of the disease. Many a case of reddened eyeball presents itself, and looks so like iritis, that the most experienced observer cannot say at once that there is or is not this affection; but the test that never fails me is trying the seeing power, and if I find no deficiency here, I am sure that there is only surface inflammation.

A surgeon in very large practice, in London, and well known to all of us, sent very lately for me, to see a patient whom he had attended with rheumatism, and now, as he supposed, afflicted with rheumatic iritis. The eyeball was much injected, and whether superficially or not, I could not tell. The iris was clear. I tried the sight, and when I found that the almost microscopic inscription on my watch could be read, I was satisfied that there was no iritis—no "eyeball-itis". The calomel and opium pill, which was just commenced, was left off, the usual diet was allowed, and an astringent lotion given. In a few days the eyes were well.

More than all this, the ophthalmoscope teaches us that the retina may be the sole seat of syphilitic action. My attention was first drawn to this in a medical pupil saturated with secondary syphilis, and who lost the sight of one eye without any external symptoms. Internal inspection, however, showed that there was inflammatory exudation over the fundus of the eye, obscuring the optic disc and retinal vessels. When I was last consulted, fortunately for him, his sight was almost clear.

Among the appearances at the fundus of the eye, after the acute stage of syphilitic eyeballitis has passed away, are dots and patches of deposit of different forms and sizes, more or less darkened with pigment, over the retina. The optic disc is often changed, sometimes contracted and ill defined, and greyish; sometimes, apparently, more spread out, and presenting many abnormal aspects. The choroid becomes patchy with white, yellow, and brown; its pigment is lost in spots, allowing the vessels to be seen, and exposing the sclerotic coat.

I must beg the gentlemen who honour me with their presence not to suppose that the ophthalmoscope has increased the difficulties of ophthalmic practice. I fear that this idea is not uncommon, on the contrary, it renders it easier, after a man has taken the requisite trouble to learn certain preliminaries. What time used not to be spent in investigating cases of impaired vision, to discover to which of the subdivisions of amaurosis it belonged? How numerous the questions, how tedious and unsatisfactory the examination? Now we at once have a peep, and see things as they are, and when we are puzzled, the patient is not made to suffer for it. I believe, too, that the ophthalmoscope will reduce ophthalmic literature; the treatises will devote less space to the diseases of vision, because less is needed. There will be more fact, which is always put in a small space, and less of wordy theory.

There is just one topic, respecting therapeutics, that I venture to introduce. Do not abandon a patient, and say that he is incurable, merely because you see this or that change in the eye; it is one of the dangers of a speciality. Let nothing short of disorganisation prevent you from seeking indications of treatment, and catch at the shadow of a chance. We know so little of the natural reparative power, of function and of vitality, that we ought not to dare, except under remarkable and well recognised conditions, to give a fatal prognosis.

Do not look on a diseased eye merely as such; remember that this organ is but a part of a whole, and that recovery, or partial recovery, often ensues contrary to the expectation of the most experienced. Which of us has not seen this exemplified in disease of the lungs, and kidneys, and liver, by specialists in these departments?

I have brought here tonight patients whose diseases will illustrate most of the morbid affections that I have described.

Allow me to thank you, Mr. President and gentlemen, for the attention I have received from you while giving these two meagre lectures. Soon, I shall give to the profession, in the new edition of my work *On the Diseases of the Eye*, a full and complete chapter on all that practically relates to the ophthalmoscope, and to which I beg to refer you for much that I could not even allude to here.

THE NEW CENSUS ACTS. The new Acts for taking the Census in England and Ireland next April have been issued. In England the Secretary of State is to superintend the taking of the Census. Every registrar's sub-district is to be formed into enumerators' divisions. Enumerators are to be appointed, and householders' schedules to be left at all dwelling-houses, to be filled up as to all persons abiding therein on the night of Sunday, the 7th of April, as to the name, sex, age, rank, profession, or occupation, condition and relation to head of the family, and "birthplace of every living person", and also whether there were any blind or deaf and dumb. There is nothing as to religious profession in the English Act, but there is in the one relating to Ireland. The schedules in England are to be collected from the houses on Monday, if possible, the 8th of April, and to be corrected if found to be erroneous. The masters of gaols, workhouses, hospitals, etc., are appointed enumerators for the occasion, and all overseers and other parochial officers are bound to act as enumerators. Returns are to be obtained of the houseless poor during the night of the 7th of April, and of all persons travelling or on shipboard.

Illustrations
OF
HOSPITAL PRACTICE:
METROPOLITAN AND PROVINCIAL.

LIVERPOOL NORTHERN HOSPITAL.

NEURALGIA TREATED BY OPIATE INJECTIONS.

Under the care of A. T. H. Waters, M.R.C.P., Physician to the Hospital.

[*Communicated by* Newton Heelas, Esq., *Junior House-Surgeon.*]

The following case illustrates well the beneficial results occasionally to be derived from the use of opiate injections in the treatment of neuralgia.

Joseph Lewis, aged 27, was admitted into the Hospital on June 6th, 1860. He had been ill about nine days, with severe pain in the head, attended with nausea. The pain was seated on the right side, not passing the median line, and proceeded chiefly from over the orbit, and the back of the head. He had had but little sleep from the commencement of the attack, and had a peculiar "pinched" expression of countenance, indicative of acute suffering. He was ordered five grains of quinine three times a day, with eight grains of iodide of potassium and half a drachm of laudanum at night, and good diet. From some peculiarity, the opium produced wakefulness, bad dreams, and, as he expressed it, made him quite "wild"; it was omitted.

He continued the quinine and iodide of potassium up to the 22nd, when he was much better, the pain being much diminished in extent; it was now almost entirely confined to one spot over the eye, from which, he said, he could distinctly trace it. On passing a coin along the margin of the orbit, great pain was felt on pressing in the situation of the supraorbital nerve. Fifteen minims of Battley's solution were injected on to the nerve; at the moment of operation, he felt great pain, but this very soon left him. The quinine was omitted, and he was ordered four ounces of wine daily.

June 26th. With the exception of two or three slight and momentary twinges, he has been quite free from pain since the injection; his aspect is improved, and much less expressive of suffering; he is anxious to have the operation repeated. Fifteen minims of the same solution were again injected.

June 30th. He has had no return of pain on the forehead since the last injection; but there is one spot on the temple where he has an occasional twinge. The injection was repeated at the seat of pain.

July 2nd. He expressed himself as being quite well, and was discharged.

On each occasion of injection, the patient suffered more or less from constitutional symptoms, similar to those produced when the first dose of opium was administered internally.

The relief obtained by the injections was of so decided a nature, as to greatly impress the patient with the efficacy of the remedy.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

CASES OF GLAUCOMA TREATED BY DIVISION OF THE CILIARY MUSCLE.

By James Rouse, Esq.

As it is possible that some of the readers of this Journal may not know the exact steps of Mr. Hancock's operation for the relief of glaucoma, the following extract from that gentleman's lecture, published in the *Lancet* of Feb. 11th, may be deemed acceptable:—"I introduce a Beer's cataract knife at the outer and lower margin of the cornea, where it joins the sclerotica; the point of the knife is pushed obliquely backwards and downwards, until the fibres of the sclerotica are divided obliquely for rather more than one-eighth of an inch; by this incision, the ciliary muscle is divided, whilst the accumulated fluid flows by the side of the knife."

If the reader will refer to the lecture from which the above extract is taken, he will find that Mr. Hancock was induced to perform the operation just described from having noticed in several cases of acute glaucoma a peculiar constriction around the cornea corresponding to the situation occupied by the ciliary muscle; the operation was followed by most satisfactory results.

The following cases are the more interesting, inasmuch as they did not present that peculiarity; and it will be seen that the operation was equally successful.

Case I. H. W., aged 46, married, the mother of children, was admitted under my care on May 4th. During the last eleven years, she had suffered from occasional attacks of pain (accompanied by dimness of vision) in the left eye. Two months ago she was attacked with pain in the left eye, which prevented her from following her usual occupations. A week ago the pain became so intense, that she could not procure sleep. During this time her sight was very limited; she could not see more than two yards before her, and then the objects looked confused: beyond that distance, everything appeared to be dense fog. She complained of intense throbbing pain in the eyeball of the left eye, circumorbital pain, and occasional flashes of light. The pain was more severe at night, and at times appeared to affect the whole head. She could not distinguish any object. On examining the eye, the cornea was found to be slightly ulcerated. The anterior chamber was very much flattened, partly from pushing forwards of the iris, and partly from the stretching of the cornea from the intraocular effusion. The pupil was large and immovable. The conjunctival and choroidal veins were large. Pressure on the eyeball caused extreme pain. She had had no sleep for a week.

May 4th, 2 P.M. The ciliary muscle was divided; a considerable amount of fluid escaped. Within an hour after the operation the pain was relieved, and she passed a most excellent night.

May 18th. She had had no pain since the operation; and, on a watch being given to her, she could tell the time; and could distinguish silver from gold. The eye had nearly regained its natural appearance. The anterior chamber was of the same depth as that of the right eye. The ulceration of the cornea had healed, leaving only a slight cloud.

May 28th. She had had no return of pain, and saw perfectly. The cornea was rapidly clearing. She was made an out-patient.

June 15th. She came to show herself, stating that she was perfectly well.

Case II. A. H., aged 47, married, the mother of seven children, looking at least ten years more than her age, was admitted on May 18th under my care. Four years ago, her sight began to get weak, not being able to thread a needle without glasses. One night in the middle of last September, she was attacked with violent pain in both eyes and around the orbits, especially the left. The following day, the pain increased in intensity, and compelled her to keep her bed. The sight of the left eye became seriously affected, vision being very limited and indistinct. The right eye was affected, but in a less degree.

In December, she came to the Hospital as an out-patient; at that time the sight of the left eye was completely lost; the pupil was large and somewhat irregular; the vitreous body was too opaque to allow ophthalmoscopic examination. The pain was so intense in that eye and side of the head, that she could not sleep. Under these circumstances, the ciliary muscle was divided. The operation completely relieved the pain; but there was no return of vision. The right eye improved very much after the operation; in fact, she was so much better that she ceased to attend.

May 16th. She again applied for advice; the right eye had become so much worse, that she could no longer see to read. She could distinguish large objects, but not sufficiently to recognise a face. The pupil was large and fixed, the cornea was flattened, and the iris pushed against it. The vitreous body was semiopaque. She complained of great pain in the right temple and side of the head. She felt so giddy, that she did not like to move about.

May 18th. She was admitted into the Hospital; and the ciliary muscle was divided.

May 30th. She had progressed favourably since the operation, the mist had entirely gone, and she was able to read for a short time without inconvenience, but it caused subsequent uneasiness. She stated that she could not look very long at an object without the eye becoming slightly "dazzled". She was made an out-patient.

June 15th. The sight was improving—every day becoming stronger. She could now look at an object for a much longer time without inconvenience. She saw everything perfectly.

August 13th. The sight perfectly good in the right eye.

She finds that if she takes cold there is slight mistiness for a day or two. During the last month there is slight return of sight in the left eye. She can now perceive the window-frames.

Case III. L. N., aged 30, single, a dressmaker, was admitted under my care on June 8th. Two years since the sight began to get dim and misty; she had had pain from time to time in the temples across the forehead; after each attack the sight was less good. A year ago, she became decidedly worse. The pain in the eyes and temples was more severe, and the sight was so much affected that she could no longer see anything distinctly. She could only read large print, and see to do the coarsest work, and this very indifferently. She had not menstruated for two years.

On admission, the pupils were large and fixed; the refractive media were turbid. Ophthalmoscopic examination showed dilated veins on both retinæ. The optic discs could only be seen imperfectly; they appeared slightly cupped. The eyes were very hard, and the anterior chambers and corneæ were flattened. She complained of iridescent vision, and pain in the eyes and head. She was given a watch, but she could not positively tell the face from the back. She thought she could distinguish very large type, but the attempt to read caused pain and dizziness in the head. The ciliary muscle was divided in both eyes.

June 18th. She had had no pain since the operation. The irides had assumed the natural size, and acted perfectly. This morning she threaded a needle, and read some ordinary sized print. She said she had not seen so well since the first attack two years ago.

August 13th. The sight continues satisfactory.

Original Communications.

SCROFULOUS DISEASES OF THE EXTERNAL LYMPHATIC GLANDS:

THEIR NATURE, VARIETY, AND TREATMENT.

By P. C. Price, Esq., Surgeon to the Great Northern Hospital; the Metropolitan Infirmary for Scrofulous Children at Margate; etc.

I.—Inflammatory Conditions of the External Lymphatic Glands in Scrofulous Subjects.

[*Continued from page* 600.]

Recognition. The correct appreciation of this form of glandular enlargement is, as already observed, of very great importance, as it at once relieves the patient of much anxiety, and enables the surgeon to adopt measures which, when correctly employed, are very frequently followed with the greatest advantage. But due recognition is oftentimes attended with difficulty, for there are certain abnormal conditions of the lymphatic and other parts, which more or less closely resemble enlargement from slow chronic inflammatory disturbance.

The following conditions are those which appear to possess a more or less close analogy. *Firstly.* Hypertrophy of lymphatic glands from apparent non-vascular derangement. *Secondly.* A true tuberculous condition of the glands. *Thirdly.* Encysted and fatty tumours. *Fourthly.* Chronic abscesses. *Fifthly.* Goitre or enlargement of the thyroid gland.

Firstly. Chronic inflammatory glandular enlargement is not always easy of distinction from that form of hypertrophy which obtains without any apparent inflammatory action. In an early stage, and when arising from any cause which is likely to lead to vascular disturbance, this kind of enlargement may, as a rule, be more generally anticipated. But there are occasions when no discriminative examination will serve to distinguish it, save that afforded by manipulation. To the touch, such enlargements will generally be found less hard, more elastic, and less defined, than those arising from simple chronic hypertrophy. Nevertheless, the pain on handling, no matter how slight, is often the only deduction that can be obtained from manipulation. In still more dubious cases, therapeutical management is the sole means which enables a correct appreciation of the nature of the affection; for while the resolution of hypertrophy, the result of a low and tardy form of inflammation, is sometimes comparatively easy, the resolution of that resulting from non-vascular causes is much more difficult. Chronic inflammation, although of a very low form, is, moreover, more rapid in its progress, frequent in its relapses, and ordinarily attacks such glands as are not commonly included in non-inflammatory hypertrophy. In young people, as well as in those more advanced in years, both forms of enlargement are frequent, although chronic adenitis is more usually the immediate result of certain appreciable causes. Both forms are met with in the cervical and facial glands, although true hypertrophy is more commonly limited, I believe, to the deeper layer of the glands of the neck, and, unlike inflammatory glandular lesions, at least, so far as I am aware, very rarely involves the glands of the armpit and groin.

Secondly. In the earlier stages of development, the greatest difficulty is often experienced in ascertaining whether enlarged glands seated in the neck, etc., result from simple inflammatory changes or from decided tuberculous degeneration. A variety of comparisons will, however, frequently enable the surgeon to pronounce as to the specific action that is taking place, although the analogy is often so strong that an early and direct decision is often impossible. The difficulty of early appreciation is, however, further increased owing to tuberculous depositions seldom ensuing before some enlargement of the glandular structure has taken place. When the increase in size is unaccompanied by any marked symptom of a decided tuberculous character, arises from any known causes, and exhibits a tendency to resolution, then, in all probability, the glandular mischief is devoid of any specific complication, and entirely depends on temporary derangement of one or more portions of the lymphatic system. At a later period, provided the affected glands have attained considerable dimensions, and that tuberculous disease exist definitely marked in other portions of the body, then it is more than probable that the deposition of tubercle has become the direct source of irritation. Should destructive inflammation ensue, and extend to the cellular tissue and skin, additional evidence will be still more in favour of tuberculous complication; while an examination of the pus, should suppuration occur, will at once decide any further doubt. But, as will be presently shown, deposition of tubercle is oftentimes unaccompanied, or followed, even at a remote period, by inflammatory changes, ending in ulceration and suppuration. A sure diagnosis in such instances is therefore, as may be readily conceived, of still greater uncertainty; and the surgeon will oftentimes have to wait patiently, till time and the use of therapeutical means have decided the correct nature of the puzzling affection.

Thirdly. Encysted and fatty tumours, when situated on the neck, especially near the base of the lower jaw, and in and over the parotid gland, often give rise to some speculation as to whether they may not be closely simulated by chronic glandular swellings. I have often myself been struck with the near analogy that exists between these various morbid conditions; and experience has taught the value of careful investigation before pronouncing as to their precise nature.

When an encysted tumour is situated near to one or more of the cervical lymphatic ganglia, an erroneous impression, without regard to certain symptoms, is by no means improbable; but if the cyst become inflamed, its due recognition, as M. Guersant has pointed out, is at once easy, by reason of the peculiar nature of its contents. One point of importance, as bearing on the diagnosis of an encysted growth is, that while it is comparatively infrequent to find a single gland included in chronic inflammation, to the exclusion of others forming, perhaps, the same plexus, it is equally rare to find more than one encysted tumour occupying the same region, without it be on the hairy scalp. Manipulative distinction, a careful insight into the nature of the origin and duration of the enlargement, and an inquiry into the constitutional habitus of the individual, will generally at once lead to a truthful appreciation.

With regard to the similarity existing between fatty tumours and simple chronic inflammatory swellings of the lymphatic ganglia: I have known such growths, occupying the region of the neck and armpit, to give rise to the suspicion of glandular enlargement, although the soft, elastic, and generally painless character of the adipose swelling, usually allows a correct diagnosis.

Fourthly. It is by no means infrequent to find chronic abscesses presenting points of almost positive identity to this form of glandular disturbance; and the analogy is oftentimes so close, that great care is required in arriving at the real nature of the swelling. Although fluctuation is not always obtained in the case of chronic abscess, still it is generally appreciated;

and this alone will often serve to point to the right character of the doubtful tumour. But there are occasions in which, as every surgeon of experience must admit, considerable doubt is cast over the nature of a swelling suspected to consist of fluid; and I have more than once known a simply enlarged gland treated as a chronic scrofulous abscess.

Fifthly. Goître and certain specific enlargements of the thyroid gland, especially when one of its lateral lobes is only affected, may give rise to suspicions that the swelling is dependent on chronic inflammation of one or more of the lymphatic glands. I know of no better criterion whereby to judge of suspicious thyroid development than by noticing the effects produced on the gland by the act of swallowing. Should the swelling remain stationary, it will, in all probability, be a lymphatic or any other affection; but if it be associated with the movements of the upper portion of the windpipe, then, without doubt, some thyroid development will be indicated. For this practical hint I am indebted, as I am for many other valuable clinical facts, to my friend and distinguished former teacher, Mr. Fergusson, for I do not remember having seen it mentioned in any surgical work.

Pathological Changes. The simplest form of low and tardy inflammatory action taking place in a lymphatic gland is accompanied with swelling dependent on a greater or less injection of the vascular portion. Should this vascular excitement suddenly be arrested, diminution in the size of the affected gland ensues; but if it extend, more permanent increase in bulk follows, as the result of exudation. On examining a gland thus altered, it is rare to find the enlargement dependent on the existence of serous infiltration, even to a slight amount, as is usually the case in more acute forms of lymphadenitis. The increase is more dependent on a plastic material which fills up the areolar portion, and, if not absorbed, leads to a permanent thickened and consolidated condition, and the entire gland appears converted into a fibroid structure. When the mischief has been localised to one or two spots of the gland, only partial alteration ensues, and consequently only a certain portion of the glandular function is interfered with.

Under various stages of subacute and chronic inflammation, a closer investigation will afford the following particulars:—Should the enlargement be characterised by rather a high state of vascular excitement, the cut surfaces of an included gland will present a pinkish or even reddish hue. Should the fibroplastic material have somewhat universally replaced the true glandular structure, a translucent, white, firm, tough appearance, will be detected, which perhaps, on pressure, especially if of recent formation, will exude a hyaline fluid. On the other hand, if the development of fibro-plastic matter have been slight, the gland will preserve a pale yellow colour. It by no means follows, however, that because a gland remains for an indefinite period affected, its functions are lost or greatly impaired, although considerable induration with atrophy of the true parenchymatous tissue may result.

Provided, therefore, that no untoward causes, either constitutional or local, ensue during the various stages of this affection, resolution or permanent enlargement results. It has already been observed that resolution obtains through reabsorption of the exuded material, and that permanent hypertrophy depends on the formation of a new substance, which is either incorporated with the true glandular structure, or else takes its place, causing complete or partial obliteration of its functions and normal constituents. But, before reabsorption can remove this product, various abnormal conditions may overtake the gland. Inflammation, either simple or specific, is apt to lead to vital changes. Not unfrequently the mere handling of an enlarged gland is sufficient to excite increased and dangerous inflammatory symptoms; while exposure to cold and various constitutional causes not uncommonly admit the lighting up of destructive vascular excitement.

I have occasionally known frequent and, perhaps, rather rough manipulation of a glandular swelling, to lead to rupture of the minute vessels bordering the new tissue that has been formed, and thereby occasion ulceration and suppuration, especially in those instances in which a decidedly scrofulous constitution existed. It will be presently seen that a fruitful source of destruction to simply enlarged glands is the accession and localisation of tuberculous depositions. Should the additional inflammation excited pass on to suppuration, the character of the purulent fluid will be influenced in proportion to the more or less well marked scrofulous diathesis of the individual in whom the mischief occurs.

[*To be continued.*]

Transactions of Branches.

CAMBRIDGE AND HUNTINGDON BRANCH.

ON THE NEWLY PROPOSED TREATMENT OF ACUTE INFLAMMATORY DISEASES.

By James Carter, Esq., Cambridge.

[*Read at Cambridge, July 10th*, 1860.]

I wish to direct the attention of the present meeting to the subject of the nature and treatment of acute inflammatory diseases. This is at any time one of the most important questions connected with practical medicine which can engage the attention of the profession; but just now its importance and interest are greatly increased in consequence of the propositions as to both the nature and the treatment of acute diseases, which have of late been brought forward by physicians of repute and experience; and that, too, with a degree of confidence, and with such probability of more or less truth, as absolutely to demand our earnest consideration. The recently proposed theory to which I allude is a bold one: it is this, that the ordinary so-called antiphlogistic treatment is unnecessary for the cure of acute internal inflammatory diseases; and that the supposed necessity for such treatment rests upon an untenable hypothesis as to the nature of inflammation and of fevers. If, by experience, this theory should prove to be founded on truth, it must necessitate, on the part of the vast majority of us, such a degree of modification both as to our ideas of the nature as well as of the treatment of acute diseases, as would amount to a complete revolution.

It was the conviction of the great importance of this inquiry, and of the necessity of its immediate consideration, which induced me to bring the matter before the present meeting.

I think the evils of the old antiphlogistic plan, especially a too long persistence in it, have been long recognised; and I feel that I have but to appeal to the present meeting for confirmation of the fact, that for many years past there has been going on a gradual change in the treatment adopted by the majority of the profession for the cure of acute inflammatory diseases and of fevers. This change, I would remark, has been a progressive one; and that, too, continuously, uniformly, and steadily progressing in one and the same direction—namely, in the direction of conservatism; that is to say, in the *more* frequent use of means which support, and the less frequent employment of measures which diminish, the vital powers.

The active employment of depletory measures has been altogether abandoned in the treatment of many forms of disease which were formerly supposed to require them, and are much more moderately applied in all diseases than formerly. As an example, general venesection, in the practice of most of us, has, I suspect, become the exceptional rather than the general practice; and so of other antiphlogistic remedies which I need not specify. But I confess I was not aware of the extent to which the necessity of this change was admitted, by the very fact of its being adopted, until I entered upon the present inquiry.

With the object of ascertaining the mode of treating acute diseases adopted in the present day, I have carefully looked through the reviews and periodicals for the last few weeks, and I am much struck by the almost universal abandonment of active antiphlogistic treatment. For instance, in the last volume of *Braithwaite's Retrospect* (the volume for June), I find the following acute diseases referred to, which are thus treated:—*Gout.* Dr. Garrod says, give moderate doses of colchicum; and if plethoric, take a few ounces of blood; but if the vital powers be feeble, give ammonia, and no colchicum. *Acute rheumatism*, Dr. Inman says, is aggravated by venesection and purgatives; and Dr. Markham advises opium and colchicum. If pericarditis supervene, local or general bleeding to a small extent is necessary. But he says, "Be cautious not to injure your patient by depletion, nor delay too long the use of stimuli. . . . . There are many cases of pericarditis, especially the non-rheumatic, in which stimuli are necessary from the very beginning." In *tubercular pneumonia*, Dr. Gairdner says, "Give antimony, but in such doses as do not prostrate, and *combine it with diffusible stimulants.*" Mr. Fergusson advises

us, in *croup*, to give an antimonial emetic; and, if the child be unusually strong, *a leech* may be applied; while Dr. Richardson treats the same disease from its onset with chloroform by inhalation, and with such success as he has not seen follow any other remedy. *Acute sclerotitis and iritis* are treated by Mr. Laurence, of the South London Ophthalmic Hospital, not by bleeding, calomel, blisters, etc., as he formerly treated such cases; but by morphia every third hour, and simple warm fomentations. By these means he finds that the disease is far more rapidly removed than by the old plan of treatment.

These are the only acute diseases alluded to in the volume, and they are not selected from others for the purpose of supporting any particular theory.

In the *Lancet* for June 23rd, Dr. Radcliffe, "On Epilepsy and Convulsive Diseases", says: "The fact of tremor, or convulsion, or spasm, can in no single instance be urged as a plea for the adoption of 'lowering measures'. I know of no facts which show that a low diet is beneficial in epilepsy . . . and stimulants of one kind or another seem to be very serviceable. . . . . Convulsive symptoms associated with disease of an acute character cannot be—nor, indeed, is inflammation itself—any longer regarded as a sound argument for the adoption of lowering measures."

Next follow three cases of phlebitis (of the saphena vein) occurring in syphilitic patients, by Mr. Girdwood; for which "bark and sulphuric acid, with good living", and blue ointment along the course of the vein, are prescribed.

In the *Medical Times and Gazette* of the same date are reported cases of apoplectic effusions of blood into the retinæ, for which aperients, quinine, and blisters, are prescribed by Mr. Dixon.

In the preceding number of the same journal (June 2nd) is a paper by Dr. Conolly on Insanity, in which he states his opinion that the mortality of the patients is greatly diminished by the liberal amount of solid food, with stimulants, which is allowed in the Hanwell Asylum, as compared with that of other similar establishments. The perusal of other periodicals gives the same result.

We have here diseases of all kinds and degrees, affecting various structures and organs, and which but a few years ago would, I imagine, have been treated by the active employment of those means which we are now urged to employ with the greatest caution, if at all. I allude the more particularly to the fact of the *general* adoption of this modification in the employment of depleting measures; as it is, although to a limited degree only, an admission of the same principle as that contended for by Dr. Todd and his school.

But, although the necessity for this change of treatment was thus clinically acknowledged and recognised in actual practice, it was not so generally admitted in theoretical works on medicine. I need scarcely remind members present that, within the last few months, there have appeared works in which is urged not only the necessity for this degree of change, but the absolute necessity of extending the principle admitted still further—to a degree, indeed, which the generality of moderate practitioners will not be prepared to admit. In the same works, moreover, the truth of the hypotheses most commonly received as to the nature of inflammation is denied. The works to which I allude are, Dr. Inman *On a New Theory of Medicine;* Dr. Hughes Bennett's *Clinical Lectures;* Dr. Todd's *Clinical Lectures on Certain Acute Diseases.*

Before I enter upon the subject of the treatment proposed by this school, I will briefly state the theory of its disciples as to the nature of inflammation, and of acute diseases generally.

As regards inflammation, Dr. Bennett ignores the ordinarily received definition of pain, redness, swelling, and the like. He maintains that we may have all this group of symptoms without any of the ordinary results of inflammation; and that we may have the results without these symptoms. He defines inflammation as being a disease of nutrition, governed by the same laws that determine the growth and function of cells as they exist in healthy tissues—a disease of nutrition, but with the especial character that there exists an exudation of the normal liquor sanguinis. To this I would simply remark, that it appears to me that Dr. Bennett applies the term rather to a result than to the disease which has produced it. Dr. Todd also regards inflammation as a form of abnormal nutrition. They both maintain that the theory as to the nature of inflammation based upon the idea of the existence of excessive nutritive formative action is fallacious. Nutrition, they say, is perverted; but not only is it not excessive, but it actually *falls short* of forming the natural tissues. It is defective, not exaggerated, force or power. Dr. Todd distinctly states his belief that the time is not far distant when the distinction of acute inflammatory diseases into asthenic and sthenic will be discarded—that all these maladies will be regarded as more or less asthenic, and as promoting an undue waste of tissue. This is evidently the leading idea of the theory as to the nature of inflammation; and, upon it, the following propositions have been founded:—That acute disease, being essentially a form of perverted nutrition, does not require for its removal means which depress and reduce vital and nervous power; nor is it curable by the direct influence of any form of drug, except when it neutralises or acts as a direct antidote to some *materies morbi;* that, in fact, disease is cured by natural processes, to promote which vital power must be upheld. All remedies are only so far useful as they promote these natural curative processes.

I will proceed to notice the treatment of acute diseases which is advocated by the supporters of this theory. I do not know that I can better illustrate it than by a brief survey of the several works to which I have alluded.

Dr. Inman, of the Liverpool Infirmary, has published a volume of considerable bulk, which he entitles *A Foundation of a New Theory and Practice of Medicine;* and in it he advocates views precisely similar to those entertained by Dr. H. Bennett. He maintains that all active depletory measures are to be avoided; that, even in the earliest stages of disease, the mildest remedies are the best; and he says, "Under no circumstances should means be adopted which would of themselves make a healthy man seriously ill;" and, as soon as the intensity of the symptoms subsides, and even before the attendant febrile action is gone, a tonic plan of treatment should be adopted. It is simply a plan of expectancy and tonics. His leading idea is, that the theory and practice of medicine ought to be based upon alteration in *power* or vital *force*, rather than in changes of *structure;* and in this idea consists what Dr. Inman considers to be the novelty of his theory.

Dr. Bennett, in his large work, *Clinical Lectures on the Principles and Practice of Medicine*, also deprecates the active use of antiphlogistic measures, as they tend to diminish vital power, and thereby *interfere* with the cure of diseases. He does not enter into the details of treatment, but confines his remarks to the employment of venesection as a means of removing inflammation. I need scarcely say that he is opposed to such practice; and he states the reasons for his objections. He says that bleeding cannot materially lessen the *materies morbi* in the blood; he questions whether it really be good practice to diminish the flow of blood to an inflamed structure, inasmuch as blood is required for certain ulterior changes connected with cell-growth; indeed, he is of opinion that an increased flow of blood to an inflamed part is salutary, and is essential for the completion of those nutritive changes which are necessary to accomplish a cure. Perhaps I may partly explain this remarkable and apparently heterodox opinion by reminding you of Dr. Bennett's definition of inflammation; namely, that it consists of an exudation of the normal liquor sanguinis. He wishes to assert, I imagine, that a larger supply of blood than natural is needed to accomplish the resolution of this effused lymph. Dr. Bennett further states that, even if it were desirable to diminish the quantity of blood sent to an inflamed part, bleeding would not do it, inasmuch as we know, by direct observation, that the blood-corpuscles have become adherent; that, indeed, the blood in the vessels of the inflamed structure is stagnated, and cannot be withdrawn.

I will not occupy the time of the members by discussing these points, but refer them to the works themselves, and will proceed to notice Dr. Todd's work.

With this remarkable work, entitled *Clinical Lectures on Certain Acute Diseases*, left us as a legacy by the late Dr. Todd, I have no doubt the majority of members present are already familiar; but, as it was the publication of this book which induced me to bring the subject of the treatment of acute diseases before the meeting, I am sure you will allow me to refer to it, as it is the only work, so far as I know, in which the result of this newly proposed treatment is given in detail. Dr. Todd has carried into actual practice this treatment of abandoning the use of depletory measures, and the employment of tonics and stimulants, with a degree of boldness which is not a little startling.

In the preface to his *Lectures*, he clearly enunciates the proposition which I quoted in the earlier part of this paper:—That acute diseases do not require for their cure means which depress and reduce vital and nervous power. He then gives a

series of lectures on the following diseases: rheumatic fever, continued fever, erysipelas, acute inflammations generally, pyæmia, and pneumonia; and I will briefly notice his treatment of some of them, in accordance with this newly proposed theory.

Rheumatic fever, he tells us, is a state of high febrile excitement, dependent upon the presence of a peculiar *materies morbi* in the blood; and the object of treatment is to eliminate this morbid product, not by bleeding, by calomel, by colchicum, by bark, or by starving, but by alkalies and opium in large doses, by the use of all means which can eliminate the poison; by the skin, by diaphoresis, by blisters, by purging, or by the kidneys; at the same time supporting the system. Should pericarditis or endocarditis arise, he objects to bleeding even locally, and trusts entirely to free vesication; and so, if the brain or its membranes suffer, only it will be necessary in this case to omit the opium. Dr. Todd states (p. 16) that, in his whole experience, he never discovered that an endocardiac murmur was modified by any influence save that of good nourishment.

Next follow two admirable lectures on continued fever. In most forms of this malady, I suppose the necessity of depletory measures is no longer entertained; but, in the cases treated by Dr. Todd, he administers nutriment very freely from the commencement of the attack; and one cannot help being struck by the free use which he makes of stimulants. In one case of fever, occurring in a girl of 14, who, moreover, had heart-disease, an ounce and a half of brandy was administered every hour for three days, and half an ounce every hour for a fortnight longer. It may not be unnecessary to mention that the poor girl recovered.

That formidable malady, erysipelas, whether of the skin or of the fauces, giving rise to œdema glottidis, is also treated by Dr. Todd on the supporting plan. The treatment consists of the free administration of beef-tea and stimulants, and, if drugs are needed, bark, ammonia, and chloric ether; and that from the very onset of the attack. Indeed, in erysipelas, Dr. Todd regards alcoholic stimulants as actual antidotes to the erysipelatous poison.

In his lecture on acute internal inflammations generally, he urges that the main object of treatment is to support the vital powers and promote general nutrition during the time when those changes are taking place which tend to check the morbid process and convert it into a healing one. It is unreasonable, he maintains, to assume that a depressed state of vital power is favourable to the healing process; for how, he asks, can an important vital process go on satisfactorily where there is lack of vital power? Impressed with this idea, he is strongly in favour of the policy of upholding our patients, even in the earliest stages of acute diseases, by such proper food and stimulants as the digestive organs will bear. He regards as delusive the objections which are generally felt as to the administration of alcohol in acute inflammatory diseases, and states his opinion that the objectors are misled by the term inflammation, which is likened, in their imagination, to an internal conflagration, to be quenched by some summary means, or to be starved out—a reasoning of the most purely fanciful kind, and based upon a very imperfect view of the phenomena of inflammation. Inflammation is deranged nutritive process, in which, the waste being considerable, the supply must be proportionate; the more this inflammation draws upon the blood, the greater will be the exhaustion of vital force, and the greater the necessity for an adequate supply. In truth, you must feed inflammations, as you would other active vital processes. You must feed them, to prevent them from preying on healthy structures, and committing greater destruction. I may remark, parenthetically, that all this is in accordance with the third proposition laid down by Dr. Todd—that disease is cured by *natural processes*, to promote which in full vigour, vital power must be upheld.

It would be an injustice to Dr. Todd not to note the manner in which he employs stimulants. He gives it on the "little and often" plan—from two to twelve drachms, in a diluted state, at such regular intervals as the case demands. Do not direct so much to be given daily; but a certain definite quantity at perfectly regular short intervals, every half-hour or every two or three hours. Given in this manner, he says, alcohol may be employed in all those diseases in which a tendency to depression of the vital powers exists; and there is no acute disease in which this tendency does not exist. Alcohol, he says, acts upon the nervous system; and the popular notion that it *produces* inflammation ought to be discarded, as also the prejudice that stimulants are a mere "flash in the pan". Dr. Todd states his reasons for regarding alcohol as an aliment.

Such are some of the leading features of this remarkable work—one which will, I suspect, be more opposed than any other work on practical medicine which has appeared for many years past; but, at the same time, one which will, I believe, have a greater influence upon the mode of treating acute diseases than any other which has been produced within the same period.

I suspect we shall none of us at once adopt the principles here laid down, to the extent to which they are held by Dr. Todd. They appear, at first sight, to be so diametrically opposed to the principles which we have long regarded as true, and which we believe we have confirmed as true by a greater or less amount of experience, that the boldest man can only adopt them, as I am told by one of his pupils that Dr. Todd himself adopted them, by cautiously feeling his way, and proceeding step by step.

As for myself, I am not prepared to advocate the principles laid down to the extent to which they are held by Dr. Todd's school—far from it. I am not prepared to ignore whatever amount of experience I may have gained—to abandon the use of therapeutic means of known value. For instance, I shall not be readily induced to abstain from the employment of active antiphlogistic remedies in the earliest stages of inflammatory affections; although, at the same time, I suspect it is one of the most frequent errors in practice to persist in the use of depletory measures too long, and to delay the commencement of the upholding treatment. I must, however, confess that I do incline strongly to the belief that, in any future change in the treatment of acute diseases, the movement will be in the same direction as that pursued by Dr. Todd. It has of late modified my own practice; and so satisfied am I with the results, that I shall certainly persist in the same course.

As regards the treatment of acute diseases generally, then, as at present adopted, I conceive that matters stand thus:—We have, on the one hand, a vast majority who either openly recognise, or admit by actual practice, that acute diseases do not require that active employment of antiphlogistic means which was formerly supposed to be necessary for their cure; on the other hand, we have men of eminence and great practical experience who maintain that the employment of these so-called antiphlogistic means is not necessary at all. The question to be decided is, At what point are we to define the limit? This I believe to be a point of the greatest practical importance to decide.

It is, I take it, one of the especial objects of these our periodical meetings to open up for discussion practical questions of this kind. It must, I am sure, be productive of advantage, in a progressive science like medicine, to review from time to time the leading theories which influence the practice of our art. This is a most effectual means of averting a calamity which ever threatens—that of falling into a blind, unreflecting routine. I therefore do very earnestly invite the members now present to give us the results of their experience as bearing upon this inquiry, as it is only by the combined efforts of many observers that, in questions of this kind, truth can be elicited.

CASE OF PRIMARY SORE RESULTING FROM CONTACT WITH A PERSON SUFFERING UNDER SECONDARY SYPHILIS.

By George Johnson, Esq., Cambridge.

[*Read at Cambridge, July 10th*, 1860.]

M. E., a plasterer by trade, about 35 years of age, and single, consulted me in November 1854, for a supposed case of hæmorrhoids, for which he had been treated during three or four years, at various intervals. On examination, I found an extensive crop of condylomatous growths surrounding the verge of the anus; and, on further examination, I found patches of secondary syphilitic eruption, particularly on the temples; and also a sore at the angle of the mouth. He stated that, five years since, he contracted a sore on the penis, and was supposed to have been cured by a gentleman at Ely. I put him under proper treatment, and he soon recovered.

On January 1st, 1855, I was requested by M. E. to visit a female to whom he was engaged to be married, and who was suffering from a bad breast. On examination, I was puzzled as to the nature of the sore, which surrounded the nipple, and was of the size of a five-shilling piece, excessively indurated, and with everted edges. On asking her some questions, the poor woman, with tears in her eyes, confessed that M. E. was

in the habit of sucking the nipple; and this at the same time that he had a sore at the angle of the mouth.

I put her under mercurial treatment, with black wash to the sore; and it quickly healed.

I may here state that she had been, before I saw her, under medical treatment for some weeks. I was again sent for about two months after the sore healed; and found her covered from head to foot with syphilitic eruption, and with ulcerated throat. I put her under the treatment usual in such cases, and she gradually recovered, and has remained well ever since.

Progress of Medical Science:

AT HOME AND ABROAD.

PRACTICE OF MEDICINE AND PATHOLOGY.

DIPHTHERITIC PARALYSIS.

Dr. James R. Reynolds has published in the *New York Journal of Medicine* for May 1860, an interesting paper on diphtheritic paralysis, based on the histories of seventy-seven cases. He observes that M. Trousseau has described the disorder in his lectures; and that from time to time during the past and the present century, it has been noticed, by M. Chomel, Dr. Bard of New York, etc. He then goes on to give a description of the paralysis; from which, on account of its completeness, and its interest in regard to a subject which has as yet only partially received attention in this country, we shall make full extracts. Dr. Reynolds, then, writes as follows:—

Symptoms. There is a certain general course through which the paralysis runs, from that but slightly marked up to that which results in death. It always begins in the soft palate, either by numbness, loss of power of one-half or of the whole curtain; next amaurosis or strabismus, if the eyes are at all affected, always follows after paralysis of the palate, and before the extremities become involved. Deafness may follow amaurosis; then the lower limbs become affected, next the upper extremities, then the muscles of the alimentary canal and bladder, the respiratory muscles, and in some very rare cases the muscles of the heart. The paralysis may not be confined to loss of motion, for in a majority of cases sensation is either modified or lost. There are many cases recorded, where the disease has not gone on to loss of motion, the nerves of sensation only being affected; or in others, sensation being much modified, is associated with muscular feebleness. Very many cases have been limited to loss of power and sensation of the soft palate. The invasion of these different parts comes on slowly, gradually involving one limb before it extends to the other. But it is necessary to examine into each symptom more closely.

In most cases every trace of the primary disease has disappeared, the patient sleeps, eats, and digests well: yet many cases emaciate and a marked pallor overspreads the face; and, if a child, it may become irritable. This state lasts, as a rule, from two to three weeks, when the patient experiences some slight difficulty in articulating distinctly, being unable to pronounce the labial consonants, or the sense of taste at the back of the tongue is altered, and the voice may become feeble; but if the paralysis goes on, it is always accompanied by the *nasal* tone of the voice, and the regurgitation of liquids through the nose. Frequently the nasal voice and the regurgitation through the nose, are the first symptoms to call attention to the disease. If you now closely examine the soft palate, you will find it hanging relaxed; and if it is pricked, there is no contraction of it, nor does it give the patient pain. Sometimes but one side of the soft palate is paralysed, which you recognise by its relaxed condition and irregular outline, the uvula being drawn towards the sound side. These symptoms may continue a day or two, or they may entirely disappear, the disease extending no farther; or the eye may become affected, and, when it does so, it always follows the throat-affection, and precedes the paralysis of the limbs. The sight may become enfeebled, obscure; or the patient becomes far-sighted or near-sighted; or again, as in M. Trousseau's case, where there was myopia for fifteen days, then the vision became presbyopic. Amaurosis may be either partial or complete. The external muscles of the eyeball also, in many cases, become involved, leading to different varieties of strabismus.

Amaurosis is not more alarming, even when it becomes complete, than any of the other symptoms, passing off in from several days to three months. There is one case recorded where there was total blindness for three months and recovery, leaving no indistinctness of vision. Though in many cases amaurotic eyes, consequent upon diphtheritic poison, have been thoroughly examined by the ophthalmoscope, and by the most competent oculists, no lesion could be found, except in the case recorded by Mr. Dixon, of the Ophthalmic Hospital, London. In this case the vision became impaired first and more markedly in the right eye; could see better in bright light; and vision much improved with the convex lens. Examination by the ophthalmoscope showed the retina of the right eye somewhat thickened, and to be much better supplied with blood-vessels than that of the left side. The patient recovered in two months by sea-air and bathing, iron and quinine. Mr. Dixon had seen four cases of impairment of vision following diphtheria, similar to the above. As troubles of the eyes are not rare in disease of the kidneys, the urine has been carefully examined, and while in some cases it contained albumen, yet, in some of the most marked cases of blindness and complete paralysis of both sensation and motion, no albumen appeared during the whole course of the disease.

Any disturbance of the organs of hearing is rare; and, when there is either slight deafness or ringing in the ears, it occurs either before, or simultaneously with, the extension of the disease to the extremities. But paralysis, though total as far as the palate and vision are concerned, may extend no further. In the regular order of invasion comes the paralysis of the extremities; and of the extremities the legs are attacked the first. Only one patient was seen by M. Maingault, who has the records of forty-three cases where the paralysis began in the upper extremities, and in this case the disease did not involve the legs; the paralysis of the soft palate was nearly well, having been treated by electricity, when feebleness, prickling, loss of sensation, and paralysis of motion of the hands first, and then of the arms, took place.

The sick one may attempt to rise from the bed and walk, and then finds, much to his surprise, that one leg is quite feeble or becomes easily wearied; or while walking he may feel that the movements of the leg are uncertain, and that he easily stumbles and falls; and again, he finds it impossible to ascend or descend stairs, or to walk over uneven ground. Or the commencement of the disease in the leg may simulate the crawling of ants, and this goes on until it is superseded by numbness, and this may be the extent of the disease; or the feebleness may go on to total paralysis. In the majority of cases the paralysis is not complete, but the movements are uncertain, and sometimes resemble those of a drunken man. When both legs are affected one is more markedly so than the other, but this applies especially to the upper extremities. In some cases the paralysis is so complete that the patient is unable to move even a toe, but generally some little time before it becomes so complete, the patient will complain of his feet being very cold, and no feeling of warmth is experienced even when the cuticle becomes blistered by heat. Also during the course of the paralysis, some complain of acute articular pain. I say nothing for the present about the modifications of sensation. During the course of the paralysis of the legs, if it is to extend, the same primary symptoms show themselves in the hands, forearms, arms, and shoulders. There is first feebleness, weariness, prickling, numbness, and eventually more or less marked paralysis, but as has been before remarked, the two sides are very unequally affected. The paralysis in many cases gradually progressing, involves also the muscles of the neck, so that the patient is unable to hold up the head, and also the muscles of the trunk, and the muscles of the face.

When the paralysis involves the muscles of the face, which it does in rare cases, its expression is quite altered, the lips hanging flabbily, and the saliva running out of the corners of the mouth; and as one side or set of muscles are generally more affected than those upon the opposite side, the expression given to the face is sometimes hideous. Under these conditions the tongue is often tremulous. When the paralysis extends still farther, the alimentary canal and bladder become involved, and though not always, yet generally they are affected together. When the muscular coat of the intestines becomes paralysed, there follows obstinate constipation; there is no desire to go to stool; and the fæces, at least those in the lower part of the rectum, escape involuntarily, in little masses; and if the bladder is affected, the urine dribbles away, drop by drop.

One case is recorded where no action of the bowels could be effected within twenty-three days.

The genital organs do not escape, as is shown in a case already related; in fact, in some men, the venereal passions and the virile powers do not return until some little time after all the other symptoms of the paralysis have disappeared. It is exceedingly rare for the respiratory muscles to become implicated. Contractions, cramps, or twitchings of the muscles are also very rare. In those cases where the limbs are flexed, there is apt to be pain in the joints, and much pain is given when forcible extension is made. Fortunately, it is very rare for the muscles of the heart to become implicated; and in those cases where it occurs, it is shown by a slow feeble pulse, palpitations, or tremulous, fluttering contractions of the organ, and cold extremities, with pale cool skin. Often abnormal bruits are heard in the vessels, especially in those of the neck. Some cases have been attended with a slight cough and expectoration of fœtid mucus, if the pharyngeal muscles were not totally paralysed. From the impoverished condition of the blood, the extremities sometimes become slightly œdematous, but there are no cases recorded where there was general anasarca.

So far, in the minute description of symptoms, I have confined myself to those involving the motor system; but some of the very earliest symptoms, as well as those of the highest interest, are connected with more or less modification of the sensory system. There may be paralysis of motion and no alteration of sensation; this may occur in a limb, or in the soft palate,—as can occasionally be shown in cases where there is the nasal voice and some regurgitation of liquids through the nose, by pricking the soft palate, sometimes it will cause nausea and pain, though with regard to motion it is perfectly paralysed. In fact the prickling sensation in a limb is frequently the first symptom to indicate that it is invaded. Many cases occur where the soft palate is paralysed—both motion and sensation gone—while the disease in the limbs is confined to some modification of sensation, either prickling, formication, or anæsthesia more or less complete, but the motor power remaining normal. In some patients where there is complete paraplegia, sensation is not equally perverted on either side, there being anæsthesia of one leg and hyperæsthesia of the other; but these extremes are more apt to occur where the paralysis has invaded the system to a more marked extent, when there may be more or less loss of sensation of the legs, while along the spinal column the sensibility of the integument is heightened. In exceptional cases where the paralysis of motion is nearly or quite the same in both legs, sensation may be altered in but one. When the sensibility of a limb is increased, the patient may, in rare cases, complain of more or less pain in or around the joints. In those cases where the disease of the limbs is confined to modification of sensibility, the power of motion being perfectly normal, the patient walks with the sensation of the feet and legs asleep, or he may "seem to walk in the air, not feeling his feet touch the ground." The impairment of sensation and motion may confine itself to one limb or only one side—partial or complete hemiplegia—or to the lower half of the body—paraplegia, or again, there have been cases where the right leg and the left arm were paralysed. M. Trousseau relates the history of a female attacked with diphtheritic paralysis, where it was not confined to, or stationary in, one limb or side, but changed from day to day from one limb to another; but was there in this case no hysterical element? In one case, where the paralysis was confined to the soft palate, there was for some time most obstinate hiccough; whether this was merely accidental, or whether the diaphragm became involved, more extended observations only can decide.

With regard to the mind, it is but rarely affected, and in these exceptional cases the mental powers seem to act lazily, slowly, and the memory seems for the time being to be a little impaired, surrounding objects and passing events making but a slight impression, and are soon forgotten. There is never any fever, in fact the skin is apt to be too cool, and the feet are frequently cold.

Diagnosis. During the last ten years cases of paralysis have been observed following many of the grave acute diseases, as typhoid fever, dysentery, varioloid, etc., and these are now recognised as not consequent upon any lesion in the brain, or spinal cord, but from the impoverished condition of the blood acting upon the nervous system. The same may be said with regard to that variety of paralysis in children resulting from the irritation of dentition, or the impoverishment of the blood from prolonged diarrhœa, etc., yet the paralysis consequent upon the poison of diphtheria has been confounded until the last few years, and it is sometimes still confounded with that following the above-named diseases. When it has been confined to the throat, on account of the change in the voice and regurgitation of liquids, it has been supposed to have resulted from syphilis. In females it has been taken for hysteria—the case related by M. Trousseau, where the paralysis changed day by day from one limb to another, seems at least to have been modified by, or complicated with, hysteria. In other cases, again, it has been mistaken for general progressive paralysis, consequent upon some essential lesion in the great nervous centres; and also with idiocy, from the difficulty of articulation, nasal voice, pale, sad, and sometimes stupid expression of the face, the unsteady, tottering gait, and frequent falls. Other cases have been attributed to tubercular diseases of the meninges of the brain. But the period of its occurrence, and the regular progressive order of its symptoms, will generally distinguish it from paralysis following other diseases.

Prognosis. The prognosis is favourable. Of the seventy-seven cases that I have examined, there were nine deaths recorded. In two, death was caused by masses of meat entering the larynx, and plugging up the trachea. One died with convulsions, one with kidney disease, one from starvation, and the other from depression of the nervous force, seemingly in an attack of syncope—in one of these four there was a low grade of delirium before death. In all the deaths autopsies were obtained, except in two of those in which death resulted from extension of the paralysis. In the two which seemed to die from syncope the lungs were somewhat congested; in one the kidneys were violently congested, while they were perfectly normal in the one that was slightly delirious previous to death, also in this one the heart was large and the blood in it was very black and liquid. All other organs were healthy in both.

Cause. Bretonneau considered the paralysis following diphtheria was due to the extension of the false membrane up through the nasal fossæ, and especially the change of the primary acute diphtheritic disease into the chronic; but this explanation is quite untenable.

There have been well marked cases of diphtheritic paralysis where the primary affection was very light, and where the false membrane was quickly removed; in one case it lasted but four days. Albuminuria has been assigned as the cause of the paralysis; but in the majority of the cases, though the urine was daily examined for albumen, none could be found, either during the acute primary disorder or during the subsequent paralysis. Then, again, albumen has been said to be closely associated with the amaurosis of diphtheria; but facts disprove it.

Paralysis of the soft palate was at one time supposed to be caused by cauterisation of the throat, but many cases have occurred where the throat was not touched. I do not know that I can give the present opinion better, as also the former and present teaching of M. Trousseau upon the cause of paralysis of diphtheria, than in the words of the Paris correspondent of the London *Medical Times and Gazette*. "The palate and pharynx being more usually affected with paralysis than the system generally, M. Trousseau was for a long time under the impression that the loss of power was dependent on inflammation of the coats of the nerves supplying these parts, and on infiltration producing pressure on their motor muscles, and this opinion he even ventured to publish in the *Archives de Médecine* some eight or ten years ago; but he now believes that loss of power and sensibility is the direct consequence of the diphtheritic poison acting generally on the system, and strangely modifying the blood."

Treatment. The treatment of these cases can be summed up in a few words; in fact the disease will, in time, get well of itself. Tonics, as iron, quinine, good food, and good air, with sea-bathing. In some cases sulphur baths have acted very satisfactorily. Frictions to the spine, also currents of electricity applied along the spine and over the paralysed limbs, have given much satisfaction. Some of the special nervous stimulants are highly recommended, as strychnine and nux vomica. It is the opinion of M. Trousseau that to do any good with strychnia it must be pushed up until it produces some itching of the skin (of the tincture of nux vomica he gives from five to ten drops daily), and he thinks that under their use he has found the appetite to increase and the digestive organs to recover their wonted tone. Sometimes, from total paralysis of the muscles of deglutition, and also from fear of the introduction of foreign bodies within the trachea, it may be necessary to introduce the food through an œsophageal tube.

TETANUS TREATED BY LARGE DOSES OF CAMPHOR AND OPIUM.

Dr. W. C. Van Bibber reports in the *Maryland and Virginia Medical Journal* the case of a labourer, aged 42, in whom tetanus resulted from a large spike-nail penetrating the foot, which was not removed until the second day after the disease was developed. The spasms commenced violently on the fifth day after the accident, and continued nine days. The patient had opisthotonos and trismus. The treatment was by opium and camphor. The average quantity taken was 80 grains of the former, with 160 grains of the latter, every twenty-four hours for nine days. After which there were no more spasms. The whole quantity of opium taken was about 700 grains, with double the amount of camphor. The patient was beyond the average height, weight, and strength, and possibly this amount of opium might not have killed him when in health; still, the physiological effects were so disproportioned to the amount given, that it is therapeutically fair to conclude the force of the remedy was exerted in controlling the disease. (*American Journal of the Medical Sciences*, July 1860.)

LETTERS AND COMMUNICATIONS.

Letters or communications for the Journal should be addressed to Dr. Wynter, Coleherne Court, Old Brompton, S.W.

Letters regarding the business department of the Journal, and corrected proofs, should be sent to 37, Great Queen Street, Lincoln's Inn Fields, W.C.

British Medical Journal.

SATURDAY, AUGUST 18th, 1860.

SPECIAL HOSPITALS.

The special hospital question has so far ripened, that the *Times* has taken it up in a very temperate leader, in which it treats the general hospitals as the orthodox establishments, and the special hospitals as nonconformists. We cannot quite agree with our contemporary, however, in stating that the nonconformist specialists object in a very vague manner to the orthodoxy of the general hospitals—their argument is, on the contrary, plain enough. They say, "You have a plethora of patients in your great hospitals, and a paucity of medical officers; you have too much work, and therefore cannot do it thoroughly; take us unto yourselves, and special hospitals will cease out of the land; the poor will be better cared for, and science will be advanced."

This is a very good argument, as regards the monopoly by a few leading men of our great hospital appointments; but we scarcely think that it meets the question. Double or treble the staff in each hospital, absorb all those gentlemen who are at present working out a line for themselves in specialties; and will the evil complained of be remedied? We believe not. The temptation to establish these *chapels of ease* to the great establishments will be found as great as ever, as the aspirants for medical fame and position must always be in advance of the means of satisfying their ambition.

That there will always be a tendency to split the practice of medicine into specialties, we cannot doubt. The science is becoming so enlarged, that one mind can scarcely grasp it in its vast breadth and microscopic detail at the same time. We must therefore endeavour to direct this inevitable tendency, and not ignore it altogether. We have so often insisted on the necessity of working in this direction by the establishment of special wards in our existing hospitals, that we almost fear to weary our readers by repeating our argument. Yet we are convinced that this is the only way of meeting the difficulty, composed as it is of scientific, financial, and educational elements. Let us endeavour to introduce division of mental labour within our great public hospitals; and then we shall have less occasion to combat specialties in every direction without. We confess that the difficulties in the way of working out the problem in this manner are great. Old institutions cannot easily accommodate themselves to our wants; but let the want be frankly recognised, and we have no doubt that things will in time work themselves right.

Meanwhile, the profession should come to some understanding as to those specialties which form undoubted exceptions to the general rule with respect to the advisability of unity in the treatment of disease. At the present moment, there is a ludicrous eagerness on the part of certain specialists to prove to the profession that their's is the only exceptional case; but we are beginning to find these exceptions pressing in such numbers, that, if we admit them, we may well ask what is to become of the rule. In these matters, the old cry of "nothing like leather" must be set aside, and the profession, once in possession of the fair line to be drawn between what pertains to the special and what to the general hospital, should resolutely set its face against any farther infringement of the rule it establishes.

THE COLNEY HATCH TRAGEDY.

The trial of the two attendants, William Slater and William Vivian, at Colney Hatch Asylum, for the manslaughter of the lunatic Swift, is postponed. Nevertheless, without in any way prejudicing the case against the prisoners, we may be allowed to make a few remarks upon it. The Commissioners in Lunacy, apparently following the lead of their chairman, Lord Shaftesbury, have from time to time thrown out hints in their reports as to the advisability of closing private asylums, and transferring their patients to public establishments. This leaning towards an aggregation of middle-class lunatics in gigantic buildings, has been mainly justified by a supposed superiority of treatment to be found in public asylums. According to Lord Shaftesbury, the evils of private asylums are brought about chiefly by the greed of their proprietors. The want of sufficient attendants, and of a strict supervision of their acts, has been always dwelt upon by his lordship as among the prominent evils of proprietary houses for the insane. Provide an establishment with a responsible head, select the attendants for their humanity regardless of expense, and then the cruelties perpetrated in private houses would cease to exist.

Such has been the argument ever held by the supporters of public lunatic asylums. Yet is it not strange that the two latest and most glaring outrages connected with the treatment of the insane, have occurred in public asylums?—we refer to the scrubbing of a poor lunatic on the bare stones some years since at Bethlehem, and the deplorable assault upon poor Swift, which has just ended in his death at Colney Hatch. Every condition of publicity was present in both of these cases, and yet we question if the private asylums for half a century have matched them in cruelty. We do not for one moment

intend to say that there is any inherent vice in public lunatic asylums which renders them more liable than private asylums to these outrages upon humanity; we merely wish to draw the attention of the chairman of the Lunacy Commissioners to the fact that the savage nature of a bad attendant cannot possibly by any amount of publicity be checked, and that the principal argument for the absorption of the private into public asylums therefore falls to the ground.

As usual, the defence for the prisoners was based upon "the conflicting testimony of the medical men". In a tussle, a few days previously to his death, Swift, it appears, attempted to strangle an attendant named Gunn, who, in self-defence, admits that he hit the patient as hard as he could on the pit of the stomach. Now, the view taken by some of the medical witnesses before the coroner and magistrate was, that possibly the fracture of the eleven ribs and the sternum, discovered upon the *post mortem* examination, was a consequence of this blow; and that it was just possible that a lunatic might receive such an injury without complaining of it. Other medical witnesses totally denied this position, and objected to the proposition that a lunatic feels less than sane individuals. And here the counsel for the prisoners thought he had an admirable opportunity of repeating the old cry of "When doctors differ," etc. But we think these two apparently conflicting statements are quite reconcileable. There can be no doubt that a lunatic, under powerful excitement, might receive the most deadly injuries without noticing them at the time. The same thing, in fact, occurs with soldiers on a field of battle. The nervous system cannot expend its whole energy on two distinct points of the body at the same moment. When the unfortunate lunatic grew calmer, however, the terrible injury he had received must have made itself felt. Hence one medical man might say with perfect truth that a furious lunatic is less sensible to pain than a sane person; and another, having reference to his calmer moments, might with equal truth deny it. The question of susceptibility to pain in lunatics was only spoken of generally; but the counsel skilfully managed to take advantage of it in his client's behalf. If it should be proved that the poor lunatic's chest was crushed in in the padded room, we must admit that the very means so assiduously taken to prevent patients from injuring themselves can be made available by the keepers to perpetrate the most cowardly assaults upon those entrusted to them, in silence and comparative security.

THE WEEK.

The annual circular of the *Medical Directories* has been forwarded to every medical man in Great Britain and Ireland; from which we learn that important alterations are to be made in these Directories, in the wisdom of which we entirely concur. Hitherto there have been three Directories for the three divisions of the kingdom; for the future, they will appear in one volume, at a cost so trifling, compared with the magnitude and importance to the profession of the work, that it will become almost a duty in every practitioner to support the enterprise of the publisher, who will incur great risks in giving so much for so little in return. But we understand that his subscription list has so increased since the Medical Act has passed, that he feels himself quite justified in adopting the alteration alluded to.

Sir James Clark has resigned his office as one of the members of the General Council of Medical Registration and Education nominated by the Crown; and Dr. William Baly has been appointed his successor. The retirement of Sir James Clark from the Council will, we are sure, be received with universal regret; as, unbiassed by connexion with any of the medical corporate bodies, and believed to entertain liberal views regarding the profession, he has enjoyed general respect and confidence from the time of his nomination as a member of the Council. Of his successor we will only say, that we hope the best from him as a member of the Medical Council. He has long been before the medical literary world as an able physician and writer, and at present holds the post of extraordinary physician to the Queen.

The physicians attached to the Japanese embassy which has lately visited America, have attracted a fair amount of attention in the medical world of that country. On the occasion of the embassy visiting Philadelphia, they were introduced to the notice of Dr. Gross, the able surgeon, who is also principal editor of the *Philadelphia Medical Examiner*. From a recent number of that journal, we learn that Dr. Gross performed the lateral operation of lithotomy in their presence; but that this procedure was previously unknown to them, the high operation, introduced by the Dutch, being in favour in Japan. They were much interested in the anæsthetic use and effects of ether, and were to take a supply on their return to their native country. Amputation, and the use of the ligature for arresting hæmorrhage, are said to be unknown in Japanese surgery. They perform the ordinary operation for hare-lip; and the operation of catheterism is familiar to them, in which they employ the silver catheter and the gum bougie. They use a trocar, somewhat different from the ordinary one, for tapping hydrocele and ascites. In the surgery of the eye, as well as in all the greater operations, they have no experience. They are conversant with the temporal, carotid, and radial pulse, and recognise the heart as the prime source of the circulation; but, beyond this, the whole subject of the circulation is unknown to them. Vaccination was introduced into Japan about six years ago; it was formerly the custom to insert the virus in the mucous membrane of the nose, but now the operation is performed on the arm.

PAYMENT OF SUBSCRIPTIONS.

"*Subscriptions.* The subscription to the Association shall be One Guinea annually; and each member, on paying his subscription, shall be entitled to receive the publications of the Association for the current year. The subscription shall date from the 1st January in each year, and shall be considered as due unless notice of withdrawal be given in writing to the Secretary on or before the 25th of December previous.

"If any member's subscription remain unpaid twelve months after it shall have become due, the publications of the Society shall be withheld from such member until his arrears be paid.

Either of the following modes of payment may be adopted:—

1. Payment by Post-Office Order to the Treasurer (Sir C. Hastings, M.D., Worcester), or to the undersigned.

2. Payment to the Secretary of the Branch to which the member belongs.

3. Members can also make their payments through the publisher of the British Medical Journal, Mr. Thomas John Honeyman, 37, Great Queen Street, Lincoln's Inn Fields, W.C., by post-office order, payable at the Western Central District Office, High Holborn.

Philip H. Williams, M.D., *General Secretary.*

Worcester, August 1860.

MEDICAL REGISTRATION.

REGISTRATION OF STUDENTS.

The following letter has been sent to us:—

Medical Registration Office, 32, Soho Square, London, W., August 15th, 1860.

Sir,—A good deal of uncertainty appears to prevail as to the regulations proposed by the Medical Council respecting the general education and examination of students.

This uncertainty has probably been increased by the circumstance that in the Report of the Committee on Education, as it appears in the twenty-fourth number of the Minutes of the General Council, the present year, 1860, has, through a misunderstanding, been fixed for the compulsory registration of students, instead of, as it should be, the ensuing year, 1861.

I think, therefore, that it would be useful and acceptable to many of your readers if the following resolutions of the Medical Council, which bear upon the subject in question, were placed before them in the following order.

"6. That after October 1st, 1861, all medical students be required to be registered.

"8. That no student beginning professional study after September 1861, be registered, who has not passed an arts examination, in conformity with resolutions 2 or 4; viz.,

"2. That, as far as may be practicable, testimonials of proficiency granted by the National Educational Bodies, according to the following list, be accepted, with such additions as the Medical Council may from time to time think proper to make.

"A degree in Arts of any university of the United Kingdom, or of the colonies, or of such other universities as may be specially recognised from time to time by the Medical Council:—Oxford Responsions or Moderations.—Cambridge Previous Examinations.—Matriculation Examination of the University of London.—Oxford Middle Class Examinations, Senior and Junior.—Cambridge Middle Class Examinations, Senior and Junior.—Durham Middle Class Examinations, Senior and Junior.—Durham Examinations for Students in Arts in their second and first years.—Dublin University Entrance Examination.—Queen's University, Ireland, two years Arts' course for the Diploma of Licentiate in Arts: Preliminary Examinations at the end of the A.B. course: Middle Class Examinations: Matriculation Examinations.—An examination by any other university of the United Kingdom, equivalent to the Middle Class Examinations of Oxford and Cambridge.

"4. That students who cannot produce any of the testimonials referred to in the second resolution, be required to pass an Examination in Arts, established by any of the bodies named in Schedule (A) of the Medical Act, and approved by the General Council; provided that such examination shall be in every case, conducted by a Special Board of Examiners in Arts."

I am, sir, your obedient servant,

Francis Hawkins.

Association Intelligence.

SOUTH-WESTERN BRANCH: ANNUAL MEETING.

The annual meeting of this Branch was held at the Torquay Club Rooms, Torquay, on Wednesday, August 1st, 1860; C. R. Hall, M.D., President, in the Chair.

Resolutions. The following resolutions were passed:—

1. That the annual meeting for the year 1861 be held at Truro.

2. That Dr. Barham be requested to act as President for the year next ensuing.

3. That without deciding the question of the relation of the Cornwall Medical Society to the South-Western District Branch, this meeting is desirous of acquiescing in the opinion of those members residing in Cornwall who entertain the views expressed by Drs. Barham and Littleton, to make Cornwall a sub-Branch, in the same manner as is adopted by the South-Eastern Branch of this Association.

4. That the rotation of the places for holding the annual meetings of this Branch, be referred to the general meeting of the Branch at Truro in 1861.

5. That Dr. Barham (Truro); Dr. Nankivell (Torquay); Dr. Littleton (Saltash); W. Pollard, jun., Esq. (Torquay); and W. J. Square, Esq. (Plymouth); be elected members of the General Council of the Association for the ensuing year.

6. That Dr. Littleton, Dr. Montgomery, A. Kempe, Esq., R. Kerswill, Esq., and J. Ward, Esq., be elected members of the Council of this Branch for the ensuing year.

MEDICAL BENEVOLENT FUND: TWENTY-FIFTH ANNUAL REPORT.

The following Report was read at the annual meeting at Torquay, on August 2nd:—

The Committee of the Medical Benevolent Fund have the grateful duty of reporting to the subscribers that their Fund during the past year has continued to meet with success.

During the year the income of the Donation Fund has amounted to £1,452:5:6, against £1,039:3:6, in 1858-59. This increase in the receipts has arisen from the effects of an appeal drawn up and circulated by the Committee. The subscribers will remember that since the year 1851, a biennial dinner has been held in behalf of the Fund. The Committee, recognising the numerous objections which have been urged against a dinner, resolved during the past year to attempt to raise an equivalent sum to that produced by the dinners, by laying before the profession and the public an appeal on behalf of the Fund, consisting of a statement of the principles upon which the Fund is conducted, and the results of its operations. They pointed out that the features of the Fund which render it peculiarly deserving of sympathy and support, are—first, that it bestows aid *privately*, so that the applicants are not obliged to advertise and make the most of their calamity; secondly, *without expense to the applicants*, as no canvassing is required; thirdly, *promptly*, as the Committee meet monthly to distribute grants. They also showed that thus privately and silently, the Medical Benevolent Fund had in the course of the last ten years distributed £7,887 to 679 distressed members of the medical profession, their widows or orphans.

This appeal, which was circulated extensively, has been responded to in a spirit of warm liberality, and called forth numerous letters approving of the attempt to abandon the practice of giving a biennial dinner. Among the munificent donors in answer to the appeal, is their old and liberal friend, Mr. Griffith, of Wrexham, who sent one hundred guineas. The Committee take this opportunity of expressing to him their sincere thanks.

The Committee have also the pleasure to report a legacy of £50 from the late Mr. Collinson, of Newport Pagnell, and a post obit bond for £500, from Mr. Charles Bailey, the interest of which is to be applied to the repairs of the houses at Chippenham, have been announced to the Treasurer.

The Committee again beg to express their thanks to the several lady collectors, and honorary local secretaries, to whose activity the success of the Fund is to be greatly attributed.

In thanking those who have supplied them with funds, the Committee cannot resist offering their humble tribute of gratitude to the Giver of all good things that they continue to be the means of alleviating some of the sorrow and misery which abound in the medical profession.

James Clark, *President.*

Reports of Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tuesday, June 26th, 1860.

F. C. Skey, Esq., F.R.S., President, in the Chair.

ON THE RELATIVE AMOUNT OF SUGAR AND UREA IN THE URINE IN DIABETES MELLITUS. BY SYDNEY RINGER, ESQ.

[*Communicated by* Richard Quain, F.R.S.]

Two cases, patients in University College Hospital, under the care of Dr. Parkes, were given, in which the observations were made hourly over a considerable period, thus enabling the sugar and urea to be compared, under various circumstances, with greater accuracy. The following are the conclusions at which the author had arrived:—

1. After the influence of food on the urine has entirely disappeared, a constant ratio is maintained between the sugar and urea.

2. After a purely non-amylaceous and non-saccharine meal, both the sugar and the urea are increased, but that during this increase the same ratio between them is observed. This ratio is 1 of urea to 2·2 of sugar.

3. Under both these circumstances the sugar could only be derived from the nitrogenous elements of the body, and, therefore, some such a ratio might on *à priori* grounds have been expected.

The author next showed that after saccharine food has been taken, the sugar in the urine, as is well known, is increased, but that this increase of the sugar is accompanied by a decided increase in the amount of urea. Thus the sugar must cause a consumption of nitrogenous matter, probably resolving it into sugar and urea. Various kinds of sugar were given, each of which caused an increase in the amount of urea, though whether one kind more so than another is not shown. These facts were considered sufficient to explain the cause of the loss of flesh in diabetic patients. The amount of urea excreted in proportion to the amount of sugar taken in as food, varied in different patients, and in the same patients at different times; and the severity of the symptoms was in proportion to the amount of urea eliminated through the influence of the sugar, whilst no relation necessarily existed between the amount of sugar excreted and the severity of the symptoms; indeed, as was well known, the quantity of sugar in the urine might greatly rise in amount with the improvement of the patient. The method of arriving at the influence of an ordinary mixed diet was to ascertain the ratio between the urinary sugar and the urea; at least, this method was sufficient in comparing various days together, provided the diet on these days were tolerably similar; for, Mr. Ringer stated, it was possible to conceive that though the amount of amylaceous matter might cause a much smaller quantity of urea to be eliminated, yet by increasing the former in the meal, the latter might be maintained at the same amount, or even increased, but a more nitrogenous matter would have been taken in with the amylaceous; the proportion of the former consumed would be much less, and consequently there would be more left to nourish the tissues. From this he thought it evident that the ratio must be obtained; for as most, if not all, the sugar generally passed off, it could be taken as a fair guide to the extent of the meal. This would explain those cases in which the improvement of the patient was accompanied with a decided increase in the amount of urinary sugar. The author showed, from the above cases coupled with two others Dr. Garrod allowed him to take, that a ratio of 1 to 4 of urea to sugar was rapidly fatal; that life can be prolonged with a ratio of 1 to 8, whilst a somewhat rapid improvement is compatible with a ratio of 1 to 15. He next stated that as the increase of the urea after a meal, in health, was probably due to the same cause as the increase under the same circumstances in diabetic patients, and as the sugar rose with it, maintaining the usual ratio (after a non-amylaceous meal), showing that they both come from the same source, if it could be further pointed out to what this increase in the sugar was due, it would explain the rise in the urea in health. After stating that it was possible that it might come from two sources, that it might be either due to some organ endowed with this function, which in diabetes is altered, or be the product of the retrograde metamorphosis of the tissue, he advanced arguments to show that in these cases the sugar is due to the former, probably the liver. He thence concluded that the ordinary rise in the urea in health, after a meal, was due to that organ; which, in diabetes, produced a less highly elaborated sugar, the urea passing off unconsumed with the sugar. The author concluded with a few facts showing that the sugar, after a mixed diet, reached its maximum in the early stage of the disease, during the third or fourth hour; whilst later, the maximum was not arrived at till the sixth hour; that after taking sugar in solution, the maximum was reached during the second hour; that the duration of the influence was longer later in the disease than at an earlier period: thus, at the commencement of the disease, the influence was lost in nine hours, whilst later in the disease it still continued after fifteen hours had elapsed. He also stated that the urea had a tendency to pass off earlier than the sugar, probably because it was more pernicious. Charts were given, showing the elevation of the temperature on several occasions after meals.

Account of the Redissection of a Preparation of Tubal Gestation which was Preserved and Described by the late Dr. John Clarke.

By T. Holmes, M.A., Cantab.

The paper described a recent dissection made of a case of tubal gestation, which was described and figured by Dr. John Clarke in the *Transactions of a Society for the Improvement of Medical and Chirurgical Knowledge*, in the year 1793. Dr. John Clarke's description pointed out only two membranes—the amnion and chorion—around the ovum in the tube. The principal object of this paper was to call attention to the existence of another membrane, external to the chorion, separable into two layers, and not forming part of the wall of the tube. The paper was accompanied by the original preparation, and a careful drawing of it in its present state.

Observations on the Intermittent Fevers of the West Indies, and on the Action of Quinia as a Specific in their Treatment.

By Hugh Croskery, Esq., L.R.C.S.I.

[*Communicated by* A. W. Barclay, M.D.]

The object of the author was to point out the necessity of a sedative treatment during the hot stage, and free purgation before the administration of the specific. The mixture he had found most beneficial was composed as follows:—Solution of acetate of ammonia, two ounces; spirit of nitrous ether, and spirit of juniper, of each half an ounce; potassio-tartrate of antimony, four grains; tincture of hyoscyamus, two drachms; tincture of opium, one drachm; to twelve ounces of camphor mixture. Of this a tablespoonful was given to an adult every half-hour until diaphoresis came on. The mixture might be either preceded or followed by ten grains of calomel, with a saline aperient a few hours later. He considered that the action of the mercurial purgative tended to assist the subsequent action of the quinia. He condemned the administration of quinine in large doses, and stated that he had obtained the most satisfactory results from its employment in small doses at repeated intervals. He believed that to administer it in any form during the paroxysm was injurious, and that the exhibition of large doses at this period of the disease was fraught with the greatest danger. The formula adopted by the author for its administration is the following:—Disulphate of quinia, forty grains; tincture of oranges, half an ounce, dilute sulphuric acid, one drachm, to ten ounces of water. Of this mixture he gave to an adult a tablespoonful every hour during the intermission, until singing in the ears or the presence of headache showed that the system was saturated by the remedy, when it was to be repeated at longer intervals, and even continued in small quantity for some days, so long as any unpleasant feelings were experienced at the time when the paroxysm ought to occur. He found that in this manner from forty to sixty grains might be given before the recurrence of the attack, and that in the majority of instances the next paroxysm was either entirely prevented or was very much modified. One large dose of the salt very often produced disagreeable head-symptoms, which prevented its repetition so as to get the system saturated with the remedy sufficiently early to obviate the return of the hot stage. In cases of severe quotidian he had occasionally given with benefit ten grains of quinine at once, along with the calomel; this, however, he considered rather as the exception. The paper concluded with the narration of five cases illustrative of the author's method of treatment. Of these cases, four were adults, and one a child nine years of age. In most of these the attack was quite recent, but in one case it had continued six weeks. The author remarked that in such circumstances the prolonged use of quinine during convalescence was essential to ultimate recovery.

Editor's Letter Box.

POOR-LAW MEDICAL REFORM.

Letter from Richard Griffin, Esq.

Sir,—In my last communication, I laid before you a summary of the number of patients attended by each Poor-law medical officer. I now forward a list of thirty unions, extracted from one out of the eleven divisions into which the Poor-law Board have divided England and Wales. In this list will be apparent the entire want of any plan in fixing the salaries of the medical officers, and the absolute necessity that exists for an Act of Parliament to determine the course to be pursued by the Poor-law Board and Boards of Guardians on the subject. At present, the payments are capriciously made; the man with the least to do having in many instances the highest salary.

This it is that prevents unanimity amongst us, and enables the Guardians to tyrannise over us, and the Poor-law Board to disregard our complaints.

South-Eastern Counties.

Name of Union.	Number of patients.	Distance of farthest patient.	Medical officer's salary.	Average payment per case.
		Miles.	£.	s. d.
Epsom . . .	1000	5	26	0 6
	171	3½	30	3 6
Guildford . .	335	8	60	3 4
	162	3	60	7 4
Hambledon . .	227	4	22	1 11
	109	3	21	3 10
Croydon . . .	1715	5½	100	1 1
	943	3½	100	2 2
Kingston . . .	905	5	60	1 3
	775	3	100	2 6
Malling . . .	284	6	66	4 7
	169	5	66	7 9
Sevenoakes . .	736	6	100	2 8
	303	4	100	6 7
Tunbridge Wells	1551	4	75	0 11
	813	5	105	2 7
Hollingborne .	561	4	75	2 8
	309	4	80	4 10
Cranbrook . .	154	5	30	3 10
	158	4	43	5 5
Tenterden . .	225	3	28	2 5
	91	2	30	6 7
Sheppey . . .	161	4	50	6 4
	61	5	75	24 7
Castry . . .	71	4	35	9 10
	35	5	30	17 1
Dover . . .	230	6	35	3 0
	37	6	25	13 6
Elham . . .	120	1	32	5 4
	11	1½	28	50 10
Hailsham . .	167	4	44	5 3
	161	5	80	9 11
Ticehurst . .	1030	3½	44	0 10
	394	5	52	2 7
Uckfield . . .	447	7	65	2 10
	250	6	70	5 7
West Tirle . .	152	4	25	3 3
	53	5	20	7 6
West Hampnett	230	4½	45	3 10
	43	4½	42	19 6
Midhurst . .	395	6	30	1 6
	132	5	38	5 9
Westbourne . .	116	6	25	4 3
	135	5	45	6 8
Portsea Island .	1146	2	42	0 8
	447	2½	42	1 10
Fareham . .	167	5	38	4 6
	89	5	47	10 5
Isle of Wight .	1377	8	70	1 0
	90	5	60	13 4
Lymington . .	1048	5½	50	0 7
	95	5½	32	6 8
Fordingbridge .	666	7	56	1 8
	490	6	90	3 8
South Stoneham	202	5½	50	5 0
	110	3	50	9 3
Andover . . .	1350	7	55	0 9
	198	7	65	6 6
Wantage . . .	278	4	30	2 1
	137	4	50	7 5

Within the last few days, I have had remitted to me from ten officers of the Grantham, Auckland, and Narberth Unions, subscriptions to the amount of £4: 5: 0. I have also received from the students of the Manchester Royal School of Medicine £2; which assistance I value exceedingly, as it has been spontaneously afforded, and comes from gentlemen who are only indirectly interested in the success of our appeal for justice. I trust the Poor-law medical officers generally will see the necessity of supplying the Association with pecuniary assistance; as £200 at least will be required to enable me to lay before the members of the legislature early next session the calculations I have already made, and without which I fear the influence of the guardians will have more weight than those of the medical officers.

I am, etc.,

Richard Griffin.

12, Royal Terrace, Weymouth, August 6th, 1860.

THE BROMPTON HOSPITAL FOR CONSUMPTION.

Letter from William H. Ranking, M.D.

Sir,—Permit me to correct an error, though not an important one, in Dr. Edward Smith's account of the origin of the Brompton Hospital for Consumption—that it was originated by Mr. Rose, a solicitor, and that there was "no medical man associated with the question." This is partly correct, but not entirely so; for the starting point of the noble institution in question was the result of a discussion between Mr. Rose and myself; and the original prospectus was written by me.

This fact, however, does not invalidate the remark of Dr. Smith, that the Brompton Hospital had no selfish medical element in its inauguration, for I purposely withheld my name, feeling assured that such an imputation would attach to the project, and in that case very properly render it abortive.

It is only justice to my relative, Mr. Rose, to state that the perfect success of the Hospital is mainly due to his untiring zeal and extensive influence.

Allow me to congratulate the Association on the admirable meeting just concluded; and to express my regret at not being a participator in so high a scientific treat. The elevated sentiments, both medical and moral, uttered by the talented president and others, cannot fail to exercise a beneficial influence on the profession at large.

I am, etc.,

Wm. H. Ranking.

Norwich, August 13th, 1860.

HOSPITAL EXPENDITURE.

Letter from William Turnbull, M.D.

Sir,—Hospital expenditure is a subject of great interest, and I am glad to observe Dr. Inman's letter in your Journal. The total expenses for the year, as given in the various reports, are, I doubt not, correct; but other points of no less importance cannot, I fear, be learnt from these annual statements. The actual number of patients treated, the cost per case, and the diseases, would interest all, and prove of the highest value. Until, however, the different hospitals adopt the same mode of enumerating their cases, no satisfactory data can be gleaned on these heads, the most important of all hospital statistics. Recommendations are generally required to be renewed every two or three months. This, I think, is very proper, as it draws the governor's attention to the case, and leaves it optional with him to renew the recommendation or not. While, however, I approve of this, I strongly condemn the practice, too often followed, of counting these renewals as fresh cases. Where this plan is adopted, it is evident that no reliance can be placed on the number of patients, as published in the annual reports; nor can any accurate calculation be made as to the cost of each case, or any knowledge obtained of the maladies which come under treatment. Let us suppose a case of rare disease to be admitted, and that it requires a lengthened course of medicine—it may be six, or it may be twelve months. During this period, the recommendation will have been renewed two or three or half a dozen times; and thus, instead of one case of this unusual malady, we shall find several entered in the books of the charity.

We, I regret to state, followed at one time this wrong path in our Infirmary; but juster views now prevail; and, although we still renew our recommendations, we do not enter them as fresh cases.

There are other sources of inaccuracy, although of much less magnitude, which are apt to be overlooked in hospital returns; as when a patient is referred from one medical officer to another—say a surgical case from the physician to the surgeon. This, I believe, is often made into two patients. It will also happen that an out-patient changes his medical attendant. To accomplish this, he obtains his discharge, and then brings a new order on a different day, and is again enumerated. All these blots on our hospital statistics ought to be avoided. It is quite as easy to be correct as the reverse. Truth is ever better than error. Wherever hospital returns are not strictly truthful they can only lead astray, instead of affording authentic materials from which many useful deductions might be drawn.

In the table given by Dr. Inman, the expenditure for drugs,

etc., seems in some places enormous. Surely what costs £60 at Colchester, cannot amount to £285 or £486 at Liverpool.

It is full time, however, that some general plan for hospital returns should be agreed upon, so that the management of one charity could be compared with that of others. Miss Nightingale has taken the subject in hand, and it will be the fault of the profession if some truthful and uniform system be not adopted.

I am, etc.,

William Turnbull.

Huddersfield, August 3rd, 1860.

ON THE PROPER USE OF STRAMONIUM IN HAY-ASTHMA.

Letter from Edward Lawford, M.D.

Sir,—My attention has been directed to an inquiry in your Journal of July 7th, as to the best method of relieving the distressing attacks of dyspnœa which are met with, at this season of the year, in those who suffer from what is called hay-fever.

I have not at present had an opportunity of seeing Dr. Salter's work to which you refer, and in which you state tobacco smoking, *ad nauseam*, is recommended as the most efficient mode of relieving the asthma which attends it. I believe there is no remedy which is more generally recommended than the thorn-apple or stramonium, introduced to our notice first from the island of Ceylon. There has scarcely appeared a work on the subject in which its merits have not been discussed, some authors reporting favourably of it, and others considering it as well nigh valueless. Smoking the herb is the plan generally recommended, and in those who are easily brought under its influence this plan is, doubtless, occasionally of considerable service; but with the majority little or no effect is produced by this mode of procedure. True, smoking, if long continued, may produce nausea and slight narcotism; but the paroxysm is urgent, and *immediate* relief is required. Under these circumstances, I have been in the habit of directing the patient to introduce portions of the stem and leaf of the plant into his pipe, as before, to smoke it, and inject the smoke thus obtained from the mouth into an inverted ale-glass; to continue this procedure until the glass is filled with the stramonium fumes, and then to place the glass (still inverted) over the mouth, and take one long and deep inspiration. The effect is instantaneous, a sense of suffocation for the moment, then copious expectoration of ropy mucus, and immediate relief.

Stramonium, in addition to its antispasmodic and narcotic properties, is a *direct, powerful, and instantaneous expectorant*, if properly applied, and in this consists its peculiar value in this distressing complaint; but in order to effect this object, it must be brought into *absolute contact* with the air-cells of the lung; simple imbibition through the mucous membrane of the mouth will not bring out its powerful expectorant properties, and hence those who have looked for benefit from smoking the drug simply, have been grievously disappointed, and have pronounced it valueless.

The above remarks apply to the relief of the paroxysm merely. I need scarcely say that during the interval attention should be directed to the state of the general health, and of the decarbonising organs in particular. In conclusion, I may say that I shall be glad to know the result of any trials made by my brother associates of this mode of direct application of the concentrated stramonium fumes.

I am, etc., Edward Lawford.

Leighton Buzzard, August 7, 1860.

THE ROYAL MEDICAL BENEVOLENT COLLEGE.

Letter from Thomas Martin, Esq.

Sir,—The other day, I enjoyed the very great pleasure of attending the annual festival of the Royal Medical Benevolent College at Epsom; it being also strictly the founder's day, the birthday of Mr. Propert, through whose public spirit, patriotism, and benevolence, the College originated, and by whose persevering and indefatigable exertions it has been brought to a successful course of operation. The able and accomplished teachers of the scholastic department, with Dr. Thornton at their head, have produced most successful results, as manifested by the students in the presence of the highly educated assemblage of visitors and friends of the institution then present.

The Earl Powis was in the chair, and we were honoured by an admirable address of congratulation and admonition by the Lord Bishop of Winchester, the visitor of the College; and by the speeches of other eminent persons.

Tested by examinations, the youths who distinguished themselves by superior attainments were adjudged appropriate rewards, in the forms chiefly of valuable books in elegant bindings, handed to the successful students by the right honourable chairman, with encouraging observations as to continued industry and still higher intellectual, moral, and religious attainments; and Dr. Thornton bore testimony to the unexceptionable good conduct and behaviour of all the boys in the establishment.

It is probable that some of the pupils may not be destined for the medical profession; but for those who are, here is an excellent school. I am a very old member of that profession, being now more than fourscore years of age; and for half a century I may be said to have been in active practice. During my long career, I may be supposed to have had a large acquaintance among the juniors who come into the profession, many of whom were not sufficiently and accurately grounded in the fundamental principles and elements of general knowledge; and the superstructure, as might be expected, not liberal nor comprehensive, so as to render students properly prepared for the subsequent strictly professional education, to be carried out at the great hospital schools of the metropolis and in the provinces. In our excellent institution, the boys who are so fortunate as to be received will enjoy the advantages of the requisite preliminary education, classical, mathematical, and general, with habits of industrious application to their studies, imbuing their minds with a love for investigation and inquiry, and a taste for liberal learning; their intellectual powers improved and invigorated, and rendered more efficient as the instruments for prosecuting science and literature; going well prepared for their medical education, so as eventually to exercise their *divine art of healing* with honour to themselves and the highest utility to the world at large.

Although I am a humble individual, I would presume upon my seniority to invoke the aid of the whole medical profession in assisting to enlarge the funds and add to the strength of this invaluable institution; as also would I invite the cooperation of the general public, who would desire to have for their medical attendants able and skilful advisers, highly esteemed as members of the profession, taking rank among the first *gentlemen* in society, and men of accomplished and most enlightened minds.

I am, etc.,

Thomas Martin.

Reigate, August 14th, 1860.

THE MEDICAL DIACONATE.

Letter from John Watson, M.D.

Sir,—I beg leave to tender my thanks to Dr. Tuke, Dr. Davey, and the other members of the Association present at the Torquay meeting, for the decisive stand they took in opposition to the Bishop of Exeter's proposed Medical Diaconate.

Had it been entertained, it must have had the effect of bringing a large section of the profession under the immediate control of the Establishment. A very little reflection will suggest obvious reasons why the influence of the Church upon these subordinate members of her priesthood must sooner or later have become paramount to every other consideration; and, however plausible or pious the motive of this proposal may have been, it is beyond question that its ultimate result would have been a lamentable blow at the cultivation of medical science, by dividing the attention and cramping the spirit of its professors. There would have been a deteriorated supply of medical aid to those classes for whom these physician-priests are specially intended, and a vast addition to the spiritual despotism already so powerfully exercised by the State Church.

However, such an amalgamation is utterly *impracticable*—not because the two professions are beyond the grasp of one mind, but on the simple ground of their incompatibility. The medical man is open to requisition at all hours, and on all days alike; while the clergyman must appropriate certain specified portions of his time absolutely and without interruption to his clerical duties. Hence would it be impossible effectually to combine the two characters in the same individual.

I am, etc., John Watson.

Southampton, August 14th, 1860.

Medical News.

BIRTHS, MARRIAGES, DEATHS, AND APPOINTMENTS.

** In these lists, an asterisk is prefixed to the names of Members of the Association.*

BIRTHS.

Of sons, the wives of—

*CRAVEN, Robert M., Esq., Hull, on August 7th.

OLDFIELD, H. A., M.D., Residency Surgeon, Khatmandoo, on June 9th.

PARRY, Edward J., L.R.C.P.Ed., at Ballymenach, Argyleshire, on August 9th.

REMINGTON, Thomas, Esq., North Brixton, on August 9.

ROSE, Henry C., M.D., Hampstead, on August 10.

Of daughters, the wives of—

KIRBY, E. A., M.D., at 1, Taviton Street, on August 13.

LE CRONIER, John, M.D., St. Helier's, Jersey, on August 6.

MACKENZIE, J. Ingleby, Esq., Surgeon, 58, Burton Crescent, on August 13.

*STEVENS, C. P., Esq., Biggleswade, on July 27.

MARRIAGES.

BATE, Frederic H., Esq., Surgeon, Ware, to Harriet, third daughter of John COOPER, Esq., of Swineshead, Lincolnshire, on August 9.

BRODRICK, Henry C., M.D., Mayne's Horse, to Ellen, second daughter of Jasper HULLEY, Esq., Macclesfield, at Prestbury, on August 8.

BURNETT, James, Esq., late H.M. Consul in the Brazils, to Susan M., second daughter of the late W. W. BROCK, M.D., of Clifton, at Torquay, on August 9.

INGLES, John C., Esq., Surgeon Royal Navy, to Mary Dora, daughter of the late *William TOMS, Esq., of Kingsbridge, Devon, at Blackheath, on August 8.

LOVEGROVE, Charles, Esq., Surgeon, Sevenoaks, to Catherine, only child of R. E. ADAMS, Esq., Surgeon, of the same place, at St. Mark's, City Road, on August 9.

MORGAN, Captain O., 38th Regiment Madras Native Infantry, to Anna M. H., eldest daughter of Charles J. SMITH, M.D., Garrison Surgeon, Vizegapatam, at Waltair, on June 20.

PROWSE, James B., Esq., Surgeon, Clifton, to Alice A. W., fourth daughter of the late Reverend Daniel G. WATT, LL.D., at Serrières, Neuchâtel, on August 2.

*RANSOM, Wm. H., M.D., Nottingham, to Elizabeth, daughter of William BRAMWELL, Esq., of Tynemouth, on Aug. 14.

VIVIAN, the Reverend F. Henry, incumbent of St. Bartholomew, Bethnal Green, to Margaret, eldest daughter of W. C. HENRY, M.D., of Haffield, Herefordshire, at Ledbury, on Aug. 9.

DEATHS.

ATKINSON, Wm. B., Esq., Surgeon, at New Cross, on July 31.

BELL, F., Esq., Surgeon, of Aldeburg, at Malvern, on July 15.

KNIGHT, Richard C., M.D., Civil Surgeon, at Bijnour, India, on June 14.

MOTT. On August 13th, at Church Stretton, aged 69, Mary Jane, wife of *Charles Mott, Esq., Surgeon.

THOMPSON, Theophilus, M.D., F.R.S., at Sutton, Surrey, aged 52, on August 11.

APPOINTMENTS.

LAWRENCE, H., M.D., appointed Honorary and Consulting Physician to the Carmarthen Infirmary.

*LEWIS, Thomas, M.D., appointed Physician to the Carmarthen Infirmary.

PASS LISTS.

APOTHECARIES' HALL. LICENTIATES admitted on *Thursday, August 9th*, 1860:—

BROWNE, Frank H., Stowe Maries, Essex
CLARKE, James H., Wantage
DOW, Henry B., Hanwell
JONES, John, Llanelly
MALLETT, William J., Bolton-le-Moors
STRUTT, George H., Tutbury

The following gentlemen also, on the same day, passed their first examination:—

APPLEYARD, James, London Hospital
BALLARD, C., Guy's Hospital
DAVEY, J. E., Guy's Hospital
GREENWELL, Baker, Queen's Terrace, St. John's Wood
GREEN, Ed., Guy's Hospital
LANCHESTER, Henry T., St. Bartholomew's Hospital
TANNER, John, Guy's Hospital
TODD, Joseph, Birmingham

THE QUEEN'S COLLEGE, BIRMINGHAM. At meetings of the Council of the College and the Committee of Council of the Theological Department, held on Tuesday week, at which the Principal (the Earl of Lichfield), the Vice-Principal (the Hon. and Rev. G. Yorke), the Dean of the Faculty (William Sands Cox, Esq.), the Very Rev. the Dean of Worcester (Dr. Peel), the Venerable the Archdeacon of Coventry (the Rev. J. Sandford), Messrs. Edward Townsend COX, Samuel Haines, John Suckling, George Taylor, John Brearley Payn, John E. Clift, etc., were present, it was unanimously agreed to remove the Theological Department from the Crescent to the east wing of the College, in Paradise Street. The following recommendations were approved, and ordered to be entered on the minutes, and reported upon by a special sub-committee, consisting of the Principal, the Vice-Principal, the Warden, the Dean of the Faculty, Mr. Samuel Haines, Mr. John B. Payn, and Mr. John E. Clift, appointed to draw up a scheme to be submitted to the Charity Commissioners:—That the Wardenship be kept in abeyance, in accordance with the Warneford Trust deed. That the income derived from the coupons of the Great Western Railway (£290 *per annum*), be thus appropriated: payment of interest on mortgages, £140; residence for Professor of Pastoral Theology, £40; resident College Chaplain, £40; resident Medical Tutor, £40; Warneford gold medal, £10; two Warneford medical scholarships, £20: total, £290. The Professor of Pastoral Theology to receive from coupons, £112; from endowments, £176; and from students' fees, estimated twenty students at £20 *per annum*, £400. The theological students to occupy the entire east wing of the College, with the use of the library and chapel, and the professor to pay out of the above fees the sum of £176, as the rent for the above accommodation. The resident Professor of Classics to receive from coupons, £45; as Chaplain to the Queen's Hospital, from endowment, £40; fees from twenty students, estimated at £80; and residence free. The resident Professor of Mathematics to receive from coupons, £45; as Chaplain of the College, to be paid out of the Warden's endowment, £40; fees from twenty students, estimated at £80; and residence free. The resident Medical Tutor to receive out of the Warden's endowment, £40; fees from twenty students estimated at £80; and residence free. The west wing to be devoted entirely to the medical department. The resident professors to find their own board, and the resident students to be boarded by their respective professors. The non-resident professors to have the free use of the lecture-rooms, chemical laboratory, anatomical room, library, museums, etc., and to receive, without deduction, the fees from the students whom their talents and industry may draw around them, but to be answerable for the coal and gas consumed in their department, also the wages of the porter employed by them, and all the expenses incidental to the lectures—namely, prospectuses, advertisements, etc. (*Birmingham Daily Post.*)

TESTIMONIAL TO DR. JAMES WATSON OF GLASGOW. The Faculty of Physicians and Surgeons of Glasgow have expressed their sense of the great services of their present President and late representative at the Medical Council, Dr. James Watson, by setting apart a sum of £250, the interest of which shall, in the manner most agreeable to himself, be devoted to the advancement of medical science and the encouragement of high attainments among the medical students of Glasgow, in commemoration of Dr. Watson's name. The occasion for proffering this honour to their President was chosen on the day on which he completed the fiftieth year of his fellowship.

HEALTH OF LONDON—AUGUST 11TH, 1860.

[From the Registrar-General's Report.]

	Births.	Deaths.
During week ..... (Boys.. 857 / Girls.. 799)	1656 ..	999
Average of corresponding weeks 1850-9	1550 ..	1227

Among the causes of death were—bronchitis, 39; pneumonia, 31; phthisis, 111; small-pox, 10; scarlatina, 37; measles, 39; diphtheria, 5; hooping-cough, 22. The deaths from pulmonary diseases (exclusive of phthisis) were 85, being 3·5 above the corrected average.

Barometer:
Highest (Fri.) 29·716; lowest (Mon.) 29·277; mean 29·534.

Thermometer:
In sun—highest (Sun. & Fri.) 119·0 degs.; lowest (Wed.) 71·0 degs.
In shade—highest (Sat.) 69·6 degrees.; lowest (Fri.) 47·3 degrees.
Mean—56·3 degrees; difference from mean of 43 yrs.—5·6 degrees.
Range—during week, 22·3 degrees; mean daily, 17·5 degrees.

Mean humidity of air (*saturation*=100), 81.
Mean direction of wind, S.W.—Rain in inches, 1·01.